United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: January 13-17, 2014

Date of Report: March 24, 2014

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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

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal to the Monitor and DOJ for review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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 Settlement Agreement Coordinator, Dawn Stoltz, did a great job, before, during, and after the onsite review. She was again available, responsive, and helped ensure that the monitoring team was able to conduct its activities as needed.

For this compliance review, the monitoring team found numerous areas of progress, but also found areas in which progress had not occurred. Some of the latter areas were of serious concern to the monitoring team, especially those related to medical and healthcare (e.g., annual medical assessments, pneumonia practices, infection control, use of protective clothing, lack of a medical quality program, absence of medical leadership). Following the onsite review, the monitoring team provided the parties with detail and, as a result, the monitoring team will conduct a mid-cycle onsite review to monitor the status of actions, follow-up, and progress towards improvements in these areas.

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

Restraint

- There were 138 restraints used for crisis intervention involving 18 individuals between 7/1/13 and 12/31/13. This was less than during the last onsite review when there were 342 restraints. The decrease was due to a change in the way the facility was gathering data on restraint incidents and because the individual with the greatest number of restraints was no longer living at LSSLC. Currently, one individual accounted for 48 of the 138 (35%) restraints. Six individuals at the facility had 10 or more restraints during the past six months and another 12 individuals had five or less restraints.
- A number of individuals at the facility wore protective mechanical restraints (PMRs) for SIB or protective devices. This included helmets, binders, mittens, wristlets, seatbelts, and coveralls. Some of the restraints or devices did not seem to fall under the state's restraint policy or protective device policy. The facility did not have an adequate way of determining categorizations of restraint. Seven individuals had more than one restraint or device. Two were considered PMRs for self-injurious behaviors.

Abuse, Neglect, and Incident Management

- There were seven confirmed cases of physical abuse, five confirmed cases of verbal/emotional abuse, seven confirmed cases of neglect, and no confirmed case of exploitation. These were the findings of 64 investigations conducted by DFSP involving 86 allegations. The facility reported that 50 other serious incidents were investigated by the facility during this period.
- There were 1423 injuries reported between 6/1/13 and 11/19/13. These included 28 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and were made available to IDTs for access on the shared drive.
- Many of the serious injuries were preceded by similar incidents not adequately addressed by further assessment or a review of related data (i.e., medication changes, increases in seizures activity).
- None of the investigations in the sample involving injuries attributed to self-injurious behavior included recommendations or discussion by the IDT regarding factors contributing to the behavioral incidents.
- The parties agreed that there be no monitoring for 15 of the 22 section D provisions that were found to be in substantial compliance during the last three or more monitoring visits. Three provisions remained in noncompliance, as detailed in this report. The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring.

Quality Assurance

- The QA program made progress in some areas. There was not yet a complete and adequate data list inventory, though the format and organization had improved. 16 of the 20 provisions of the Settlement Agreement (80%) were included. There were a number of other data sets that were in existence or were being developed, but were not a part of the QA program, such as the key indicators described in the previous report and a new G1 project.
- Data from 8 of the 20 sections were summarized and graphed. There was, however, no consistency in presentation of data, and most did not show trends over time, or analyze data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals.
- There were no QA reports. Some data were presented at QAQI Council.
- Much work was done to improve the corrective action system. There were 11 CAPs. All appeared to appropriately address the specific problem for which they were created. There were CAPs for 4 of the 20 Settlement Agreement provisions; not all departments were participating in the CAPs system.

Integrated Protections, Services, Treatment, and Support

- There was progress evident with the ISP process at three ISP meetings and two pre-ISP meetings observed by the monitoring team. The facility had received intensive training from a consultant provided by the state on the ISP development process.
- There was improvement in the risk discussions in regards to having data and assessment information that would aid in the risk discussion entered into the IRRF and available to all staff for review.
- There was better discussion occurring at the pre-ISP planning meetings. At both meetings, there were many good examples of integrated discussion regarding developing supports.
- Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs.
- IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection.

Integrated Clinical Services

- The facility made some progress in this area. A process for assessing integration of services was developed. The assessment for one individual was completed the week prior to the compliance review and, unfortunately, it was reported that several clinical areas did not participate as required.

- There was improvement in the integration of neurology and psychiatry, but work was still needed in this area. The pretreatment sedation process showed improvement. Medical participation in annual ISPs showed improvement from the two previous compliance reviews, but remained poor.
- 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.
- Most providers were using an IPN template for documentation of consults, but the results of use varied. Consultations were being reviewed and documentation occurred. In many instances, the entries did not provide any meaningful information about the consultation.

Minimum Common Elements of Clinical Care

- The facility had addressed the timeliness of scheduled assessments. Several clinical disciplines had tools to evaluate the quality of assessments, but no data were provided to the monitoring team. Some disciplines were tracking quarterly assessments and evaluating quality, but no data were reported for those areas.
- There were no systems in place to track interval/unscheduled assessments by the clinical disciplines. The risk thresholds audit process provided information for the IDTs for their response to a change in status and development of new plans.
- 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.
- Minimum common elements had been established for several conditions, but the additional steps required to use that information to determine efficacy of treatments had not occurred.
- The facility had 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

- The parties agreed that the monitoring team would conduct reduced monitoring for I2 and I3 because the facility had made little progress. The facility was not in compliance with the three provisions in section I.
- The monitoring team observed the risk identification process at three ISP meetings and noted some, but overall, very little progress made. IDTs were still not engaging in integrated discussion regarding risk levels and supports were not being monitored and revised as needed to address risks identified.
- Teams were not consistently documenting the completion of assessments and resulting recommendations. 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.

- Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

Psychiatric Care and Services

- Psychiatry services made progress and was in substantial compliance with nine of the 15 items.
- Over half of the individuals residing at the facility received psychopharmacologic intervention (181 of 338, 53%). The facility had identified a lead psychiatrist.
- The current psychiatric providers were experiencing difficulty with the level of documentation required. It was discussed with the psychiatric clinic staff during this monitoring visit that they could consider electronic documentation completed during psychiatry clinic in an effort to reduce the redundancy in the current documentation.
- Psychiatry sustained 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.
- 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, QIDP, direct care staff, and the individual).
- There were improvements reported in the psychiatric participation in the development of the PBSP. This was occurring during psychiatry clinic, however, documentation of this process was not uniform, and the psychiatrist's signature was not located on the PBSP document.

Psychological Care and Services

- LSSLC maintained substantial compliance on the six items (K2, K3, K5, K6, K7, and K11) that were in substantial compliance. LSSLC demonstrated improvements in the flexibility of the data collection system, development of behavioral systems to ensure that PBSP data are recorded in a timely fashion, are reliable, and that PBSPs are implemented as written. There was also improvement in evidence of data based treatment decisions and the referral system to ensure that all individuals that need psychological services, other than PBSPs, receive them.
- Areas in need of additional attention included ensuring that all treatment sites are using the same methodology to collect and calculate data collection reliability, IOA, and treatment integrity; and 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. LSSLC needed to document that PBSPs are consistently implemented within 14 days of obtaining necessary approvals and consent, and 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.

Medical Care

- There was little progress seen in the provision of medical services. The facility continued to lack the medical leadership that was needed to establish the clinical standards of care, promote the quality of care, provide oversight to the medical quality program, and provide leadership and mentoring to the clinical staff.
- The medical department was fully staffed with four full time providers. Participation in the annual ISPs remained relatively low.
- Facility data showed improvement in the timely completion of AMAs, but the actual date of completion of the AMAs was not clear.
- Acute care documentation frequently involved only one note and documentation of the resolution of acute conditions was infrequent. Some providers utilized a four-line format for SOAP notes, which resulted in very few words and little information about the acute conditions.
- The facility had an immunization nurse and this appeared to be very effective in ensuring that individuals received appropriate immunizations.
- More than 90% of individuals who qualified for colonoscopy had completed the screening. The facility continued to screen males for prostate cancer with PSAs with 99% compliance. Screening for breast cancer needed some improvement. Overall, very few women had cervical cancer screening.
- Pneumonia continued to present challenges. There was no good system to review individuals with a history of pneumonia in order to appropriately classify each event. For the individuals who had recurrent pneumonia, of any type, there was little evidence that appropriate diagnostics and interventions were implemented to minimize recurrence. The monitoring team found incidents of pneumonia that were not included in the pneumonia data.
- Data issues were seen in several areas. Discharge diagnoses were not always consistent with the findings in the active records.
- The facility completed external and internal reviews as required. Corrective actions were implemented and follow-up was done in most areas.
- It appeared that development of a medical quality program was proceeding without participation of the medical staff. Mortality reviews were completed as required. The absence of clinical leadership resulted in a lack of an objective review of the medical care.
- The medical department updated a number of policies and procedures. There was documentation of the training that was provided to the medical staff for medical and non-medical topics. There was an outstanding need to develop local policies based on state issued clinical guidelines. The department also needed to clearly define the fundamental duties and responsibilities of the primary care providers in written policy.

Nursing Care

- The facility staffing analysis did not include an acuity-based factor.
- The Hospital Liaison Nurse was present at the hospital during various times of the day, with a great deal of early morning hours spent at the hospital, in order to have direct communication with the physicians during their hospital rounds.
- The Infection Control Preventionist was instrumental in her surveillance of flu cases and fostered collaboration between the facility physicians and the local health department. Overall, however, infection control practices at LSSLC were problematic, even though training had been put in place. Acceptable Standard Precautions and hand hygiene had not been fully implemented.
- The facility had not been successful in achieving an acceptable zero rate for decubitus ulcers. There were three, of which two were reported as hospital-acquired. The facility also continued to maintain elevated numbers with soft skin infections.
- A plan should be put in place to ensure that these unacceptable infection control practices do not continue. The monitoring team strongly recommends that the facility consider a certified RN Wound Enteral Stoma Nurse as a member of the nursing team.
- The facility infirmary should develop guidelines for admissions, discharges, and transfers. The facility should also examine its own data as to lengthy infirmary stays, hospital discharges, and emergency visits that resulted in a return to the hospital within 24 hours.
- The monitoring team found an overall 78% rating for Nursing Assessments/Quarterly, which fell below the expected criteria of 90%.
- The quality and completeness of the ACPs showed little improvement. There should be consistency among the plans, and they should accurately reflect the individuals' problems/diagnoses. The plans should be individualized for the individual.
- The degree of omissions in the application of nursing assessments, application of protocol cards, and implementation of plans of care indicated that training had not transferred into practice sufficiently to address the health status of the individuals.
- There was an absence of a fundamental medication safety system to ensure checks and balances in the completion of physician orders to resolution, a reliable system for medication reconciliation/verification of physician's orders, transcription of the orders, and administration of medications.

Pharmacy Services and Safe Medication Practices

- As a result of inconsistent staffing, there was very little progress seen in the provision of pharmacy services. Some areas, which were observed to improve during the last compliance review, demonstrated regression.
- The pharmacists were documenting the communication with providers. While the documentation of the communication improved, resolution of the clinical interventions was not always documented. Intelligent Alerts did not appear for some frequently used medications, which called into question the functionality of the IAs at LSSLC.
- The facility struggled to complete the QDRRs.
- The MOSES and DISCUS evaluations were completed by nursing staff. The psychiatrists completed the required reviews. There were problems with the evaluations since the implementation of AVATAR.
- Under reporting of ADRs continued. The facility completed two DUEs since the previous compliance review. The format of the reviews was not consistent with that of a typical DUE. No clear plans of correction were documented in the Pharmacy and Therapeutics Committee minutes.
- The facility had yet to address some major problems that contributed to administration variances and medical participation in the variance system continued to be negligible.

Physical and Nutritional Management

- Some limited progress had been made in many areas. There was a fully constituted PNMT with all team members consistent with the previous onsite review (with the exception of the RN, who was new since September 2013). The PNMT was encouraged to track PNM-related events for individuals as they occurred through IMRT, morning meetings, and other routine meetings to determine when and if they recognized individuals who met criteria for referral to the PNMT.
- Observations during mealtimes showed noted improvements in Woodland Crossing and Lone Pine. There continued to be significant concerns in Castle Pines.
- Concerns were repeatedly highlighted throughout the week related to failure to take proactive steps to prevent issues for which individuals were clearly at risk (e.g., falls). Aggressive fall prevention is the key issue, rather than merely responding to falls as they occurred.
- PNMPs were missing key information and the pictures submitted were not clear to serve as an easy reference for staff. Plans should continue to be audited to address the weak areas highlighted in the report.

Physical and Occupational Therapy

- There was continued, but limited progress toward substantial compliance in all aspects of provision P. Efforts to improve the content of assessments were noted via audits, but only one was reviewed and it was lacking 57% of the required elements.
- There were few intervention plans with few SAPs in place for individuals with OT/PT needs and those reviewed were not well documented with an assessment and discharge summaries.
- A significant concern about falls was noted by the monitoring team throughout the onsite review and is related to this section of the Settlement Agreement. As discussed throughout the onsite week, the IDTs need to be more responsive to the incidence of falls. Equally important was the need to establish an approach to fall prevention.
- OTs and PTs are key members of the IDT. They should be notified of all ISPA meetings in a timely and consistent manner and attend as indicated. When in attendance the clinicians each have an important responsibilities.

Dental Services

- Continued progress was seen in the provision of dental services; substantial compliance was found for provision Q1. The required assessments were completed in a timely manner and most individuals were seen at least twice a year in clinic.
- The documentation of the assessments that were completed improved significantly. The documentation of annual examinations was also standardized and the new format included an adequate amount of information. These changes resulted in improvement in the information that was available to the IDTs regarding the status of the individuals' oral health.
- The number of individuals with poor hygiene ratings decreased, but improvement was still needed. The suction toothbrushing program was expanded, but lacked adequate involvement of the dental clinic. Records indicated that radiographs were being taken, but this was another area where improvement was necessary.
- A new process for review of pretreatment sedation was implemented. This process required that clinicians meet to discuss risk, benefits, and the options available.
- There were no medical or dental policies in place that broadly addressed the use of sedation and anesthesia, such as the level of sedation that was permissible in the facility and the selection of individuals.
- Refusals and problems related to poor oral hygiene were being addressed through collaborative efforts of the behavioral health services, habilitation therapy, and dental departments.

Communication

- Though there were some improvements in assessment content for those assessments completed, the provision of assessments for individuals at the time of their ISP continued to be problematic.
- There were relatively few communication plans and SAPs in place for individuals with communication needs and for those with behavioral concerns and severe communication deficits.
- There were, however, some excellent examples of communication service provision. For example, Kristi Hodges' work with psychology for one individual.
- The time in NEO for staff instruction by therapy clinicians was extended.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were several improvements since the last review. These included a re-organization of staff responsible for writing skill acquisition plans, modification of the SAP format, improvement in the percentage of SAPs that contain a rationale for its selection, improvement in the percentage of SAPs that contain a maintenance plan, and in the initiation of SAP integrity. Further, there were improvements in individual engagement and continuous progress in pretreatment sedation reduction.
- LSSLC should also focus upon ensuring that each SAP has a plan for generalization, and that there more SAPs for individuals with communication needs. Engagement targets for each home and day program site should be targeted. IDTs should ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are data based; and that SAP integrity is assessed in all treatment sites. Measures of skill training in the community need to be accurate, and goal percentages of individuals participating in community activities and training on SAP objectives in the community should be established and tracked.

Most Integrated Setting Practices

- LSSLC made progress in some areas of section T, primarily in the quality of post move monitoring implementation and documentation, as well as in the continued transition and placement of individuals into the community.
- 9 individuals had been placed in the community since the last onsite review. 19 individuals were on the active referral list. Of the 21 individuals who moved in the past 12 months, 3 were reported to have had one or more untoward events that occurred within the past six months (14%). Of these 3, 2 (67%) were successfully resolved or managed.
- The facility and DADS proposed no monitoring, for some provisions because they were acknowledged to be in noncompliance before the initiation of this onsite review. Thus, the most integrated setting practices related to ISPs, professional assessments and determinations, education of individuals and their LARs and staff, quality assurance, and obstacle identification and actions were not monitored during this review.
- In CLDPs, more information and detail regarding the training of provider staff, and preparation of the provider were necessary (T1c1). Discharge assessments were completed for all relevant disciplines, however, they did not focus upon

the needs of the individual in his or her new setting and how supports might be provided in the new home and day settings (T1d). The lists of pre-move and post-move supports were identified in the CLDPs. More work was needed to ensure that these lists were comprehensive and worded in measurable, verifiable terms (T1e).

- Post move monitoring continued to be implemented as required and maintained substantial compliance. 33 post move monitorings for 15 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed up when action was needed.

Guardianship and Consent

- The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands for both provision items.

Recordkeeping Practices

- LSSLC maintained substantial compliance with provision V1 and achieved substantial compliance with V3. Progress was seen in provisions V2 and V4.
- Twelve of 12 (100%) individuals' records reviewed included an active record, individual notebook, and master record. 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 and as per state policies. A master record existed for every individual at LSSLC. Overall, the master records were in good shape.
- Five (or more) reviews (audits) were conducted in each of the previous six months. All of the reviews were done in a fairly consistent manner, and were neatly and clearly documented.
- The URCs and data analyst improved upon their set of graphs from the time of the last review. This set of graphs adequately showed trending regarding the important data for their recordkeeping practices.
- The facility was in substantial compliance with three of the six items (50%) of section V4.

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 DADS Policy: Use of Restraints #00.1
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 Section C QA Reports for the past two quarters
o Sample of IMRT Minutes from the past six months
o Restraint Reduction Committee minutes for the past six months
o List of all restraint monitors and date training was completed
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 List of all individual that were restrained off the grounds of the facility
o List of all injuries that occurred during restraint
o LSSLC “Do Not Restrain” justification
o List of individuals with crisis intervention plans
o List of individuals with desensitization plans
o Sample #C.1: 25 records of physical or chemical restraint used in a crisis intervention for nine different individuals, drawn from the list provided in response to II.6 of the Document Request. Records drawn for this sample included: restraint checklist form, face-to-face/debriefing form, the individual’s Crisis Intervention Plan (CIP), if applicable, the documentation of any and all reviews of this use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. The restraint incidents in the sample were:
<table>
<tr><th>Individual</th><th>Type of Restraint</th><th>Date</th></tr>
<tr><td>#410</td><td>Physical</td><td>11/19/13 @ 4:10 pm</td></tr>
<tr><td>#410</td><td>Physical</td><td>11/14/13 @ 8:20 am</td></tr>
<tr><td>#410</td><td>Physical</td><td>11/13/13 @ 4:25 pm</td></tr>
<tr><td>#410</td><td>Physical</td><td>11/9/13 @12:21 pm</td></tr>
<tr><td>#410</td><td>Physical</td><td>10/24/13 @ 5:17 pm</td></tr>
<tr><td>#410</td><td>Chemical</td><td>10/24/13 @ 5:04 pm</td></tr>
<tr><td>#410</td><td>Physical</td><td>10/24/13 @ 3:23 pm</td></tr>
</table>
</td></tr>
</table>

#410	Physical	10/12/13 @ 2:00 pm
#170	Physical	11/15/13 @ 11:46 pm
#170	Physical	11/1/13 @ 2:10 pm
#170	Physical	10/16/13 @ 2:25 pm
#170	Physical	10/15/13 @ 3:28 pm
#170	Physical	10/14/13 @ 3:26 pm
#170	Physical	9/29/13 @ 1:58 pm
#170	Physical	9:29/13 @ 2:04 pm
#301	Physical	11/14/13 @ 4:40 pm
#301	Physical	9/30/13 @ 9:28 pm
#301	Physical	8:18/13 @ 9:30 pm
#301	Physical	8/8/13 @ 10:16 pm
#301	Physical	7/4/13 @ 7:50 pm
#301	Physical	6/17/13 @ 9:49 pm
#301	Physical	6/17/13 @ 10:05 pm
#401	Physical	11/13/13 @ 4:18 pm
#110	Physical	9/1/13 @ 11:00 pm
#469	Physical	11/20/13 @ 2:40 pm

- Sample #C.2: N/A

- Sample #C.3 was a sample of documentation for pretreatment sedation chosen from the last 10 medical/dental restraints including the physicians' orders for the restraint, including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred, any reviews of this use of restraint, and any desensitization plan.

Individual	Restraint type
#33	11/7/13
#221	11/13/13
#544	11/15/13
#131	11/18/13

- Sample #C.4 (a subsample of #C.1) chosen from II.5a in response to the document request. The total number of chemical restraints for crisis intervention was eight, involving two individuals. Sample size was one, 13% of the chemical restraints and 50% of the individuals. Records requested included: the restraint checklist, Face-to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. For the following:

Individual	Date
#410	10/24/13

- Sample #C.5: Restraints off-campus.

Individual	Date
#410	11/13/13

- Sample #C.6: The following documentation for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:
  - Positive Behavior Support Plans (PBSPs) for: Individual #333, Individual #410, Individual #301
  - Crisis Intervention Plans for: Individual #333, Individual #410, Individual #301
  - ISPA meeting minutes for: Individual #333, Individual #410

- Sample #C.7 was chosen from the list of all individuals for whom mechanical restraints or protective devices were used in the past six months. (The facility was not adequately assessing the purpose of each restraint, so the monitoring team was unable to categorize these restraints.) This included review of Protective Mechanical Restraint Plans, Individual Support Plan (ISP), ISP Addendums, and ISP Action Plan.

Individual	Restraint type
#546	Abdominal binder and Mittens
#511	Abdominal binder
#556	Wrist ties
#333	Helmet

<u>Interviews and Meetings Held</u>:
- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Robin McKnight, Director of Behavioral Health Services
- Luz Carver, QIDP Coordinator
- Mike Ramsey, Incident Management Coordinator

<u>Observations Conducted</u>:
- Observations at residences and day programs
- Incident Management Review Team Meeting 1/13/13 and 1/14/13
- ISP preparation meeting for Individual #326 and Individual #502
- Annual IDT Meeting for Individual #418 and Individual #551
- Castle Pine Unit Meeting 1/14/13
- 559 Home Team Meeting 1/1/13

	o Executive Safety Committee Meeting 1/16/13 o Restraint Reduction Committee 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 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 15 out of 115 (10%) crisis intervention restraints from 6/1/13 through 11/22/13 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. 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, C3, C6, C7, and C8. The facility found that the IDTs were not yet discussing and implementing desensitization strategies for most individuals who required pretreatment sedation (C4). The self-assessment also found that monitoring of restraints by nursing staff was not always completed within timelines required by state policy (C5). The monitoring team had similar findings for C4 and C5. Based on the samples reviewed, the monitoring team could not confirm compliance with C1, C2, and C6.
	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 138 restraints used for crisis intervention involving 18 individuals between 7/1/13 and 12/31/13. The number of restraint incidents had decreased since the last onsite review when it was reported that there had been 342 restraints during the review period. In part, this decrease was attributed to a change in the way the facility was gathering data on restraint incidents. Additionally, the individual with the greatest number of restraints during the last reporting period was no longer living at LSSLC. Individual #410 accounted for 48 of the 138 (35%) restraints used for crisis intervention. Six individuals at the facility had 10 or more restraints during the past six months and another 12 individuals had five or less restraints. A log of all dental/medical restraints provided by the facility included 216 instances of dental/medical restraint from 7/1/13 through 11/30/13. This did not include mechanical restraints used to provide treatment. Trend reports developed by the facility did not correlate with restraint lists provided to the monitoring team. A number of individuals at the facility wore protective mechanical restraints (PMRs) for SIB or as protective devices. This included helmets, binders, mittens, wristlets, seatbelts, and coveralls. Some of the restraints or devices did not seem to fall under either the state's restraint policy or protective device policy.

	The facility did not have an adequate way of determining categorizations of restraint. Seven individuals had more than one restraint or device. Two were considered PMRs for self-injurious behaviors. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. Observations in the homes and day programs and interviews with staff were conducted the week of the monitoring visit to gain additional information. The facility had appointed a new Director of Behavioral Health Services at the facility. She was now responsible for monitoring the requirements of section C. The state office had provided some guidance to her, particularly in terms of crisis intervention restraints. It will be important that she continue to seek guidance from the state office on meeting the requirements of the both the Settlement Agreement and the state policy regarding the use of restraints.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>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.</td><td>According to a list of all restraints implemented at the facility (Document II.5),
<table>
<tr><th>Type of Restraint</th><th>January 2013 – June 2013</th><th>July 2013-December 2013</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>342</td><td>130</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>15</td><td>8</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td><td>5</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>357</td><td>138</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>22</td><td>18</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>No data available</td><td>8</td></tr>
<tr><td>Medical/dental pretreatment restraints</td><td>157</td><td>216 (Data available through Nov 2013 only)</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental treatment</td><td>90</td><td>86 (Data available through Nov 2013 only)</td></tr>
<tr><td>Protective mechanical restraints</td><td>No data available</td><td>Insufficient data available</td></tr>
</table>
<u>Prone Restraint</u>
a. Based on facility policy review, prone restraint was prohibited.
b. Based on review of other documentation (list of all restraints between 7/1/13 and 12/31/13) prone restraint was not identified.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 7/1/13 and 12/31/13. Sample #C.1 was a sample of 25 restraints for six individuals, representing 18% of restraint records over the last six-month period and 33% of the individuals involved in restraints. The sample included 24 physical restraints, five mechanical restraints, and one chemical restraint. 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 facility and state policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • f. In 23 of the 25 records (92%), there was documentation showing that the individual posed an immediate and serious threat to self or others. o On the restraint checklist for Individual #410, staff checked aggression towards staff, SIB, and property destruction as the reason for restraint. The description of his behavior prior to restraint indicated that he was attempting to break the mirror on the tram. The FFAD did not provide additional information regarding his behavior to allow for determination that he or others were at imminent risk for harm. o The restraint checklist for Individual #170 indicated that he was hitting at staff while lying on the ground. Staff did not document attempts at moving away from him to prevent injury. • g. For the 25 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 20 (80%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. In most cases, the restraint checklist did not include an adequate description of the events leading to the behavior that resulted in restraint, however, the Face-to-Face Assessment and Debriefing Form often included a brief description. Exceptions were:	

#	Provision	Assessment of Status	Compliance
		o Individual #170 on 10/14/13 and 9/29/13 (x2) o Individual #410 on 10/12/13 o Individual #301 on 11/14/13 • h. In 25 of the records (100%), 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. All restraint checklist indicated that staff used PMAB skills and strategies included in the individual's PBSP prior to implementing restraints. Specific interventions were not described, so it was not possible to assess if staff used a full range of strategies included in the PBSP prior to the implementation of restraint. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 25 restraints, involving six individuals, 25 (100%) were approved restraints. k. In 20 of 25 of these records (80%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Exceptions were: • The restraint documentation for Individual #170 dated 10/15/13 indicated that he was upset because staff were following him. The restraint documentation did not indicate that he was engaged in any activity or that staff were attempting to engage him in any activity. • The restraint documentation for Individual #410 dated 11/19/13 indicated that he became aggressive after staff asked him to quick "picking his scabs on his face." The FFAD stated that he was not engaged in any activities, nor did staff attempt to engage him in anything. • The restraint documentation for Individual #410 dated 11/14/13 indicated that he became upset when staff would not let him go outside. The documentation did not explain why he was unable to go outside. • The restraint documentation for Individual #170 indicated that he became aggressive towards staff after asking staff for a snack. The staff response to his request was not documented, so the monitoring team was unable to determine if staff responded as recommended in his PBSP were provided in response to his request. • The restraint documentation for Individual #301 dated 11/14/13 was not sufficient for determining if staff used intervention strategies included in his PBSP for avoiding the behavior leading to restraint. l. The facility reported that there were two individuals subjected to restraints classified as protective mechanical restraints for self-injurious behavior (PMR-SIB). However, it was documented that at least 36 other individuals at the facility had restraining devices, such as binders, wrist ties, mittens, helmets, and coveralls with zippers in the back. The	

#	Provision	Assessment of Status	Compliance
		facility did not have an adequate assessment process in place to ensure that these devices were the least restrictive intervention required to effectively address the need for restraint. Sample C.7, a sample of documentation for four protective mechanical restraints (PMR), was reviewed. Of these, one (25%) followed state policy regarding the use, management, and documentation of PMR. • According to the Director of Behavioral Health Services, the facility had begun developing protective mechanical restraint plans (PMRP), as required by state policy #001.1 regarding the Use of Restraints. Two plans were being implemented. Three individuals in the sample did not yet have a PMRP in place. Plans should include a description of the individual's self-injurious behaviors, the type of restraint to be used, the restraint's maximum duration, and when to apply, remove, and monitor the restraint. A plan should be implemented for gradually reducing the use of restraint. IDTs should document that less restrictive restraints have been discussed and determined to be ineffective at reducing or mitigating the documented danger of self-injurious behavior. o Individual #527 was wearing mittens and a binder to prevent removal of her newly placed G-tube. The team met following placement of her G-tube and acknowledged the doctor's orders for the use of mittens. The team did not have a plan in place to reduce the use of her mittens. Her IHCP referenced her binder, but did not include the use of mittens. o Individual #511 had a binder to prevent removal of his G-tube. His ISP did not reference the binder. There was no PMRP in place to address use of the binder and staff were not using a restraint checklist to document monitoring of the binder. o Individual #556 had wrist ties to prevent removal of his newly placed G-tube. He did not have a PMRP in place to instruct staff on applying, removing, or monitoring his wrist ties. o Individual #333 was wearing a helmet to prevent injury from self-injurious behavior. She had a PMRP that included strategies to fade the helmet. The plan included instructions for staff for applying, removing, and monitoring use of her helmet. The facility showed little progress towards compliance with C1 regarding the documentation of restraints used for crisis intervention. PMRPs will need to be developed. 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.	

#	Provision	Assessment of Status	Compliance
		2. Ensure that all IDTs are holding adequate discussion regarding the use of 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.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 24 physical restraint records involving the six individuals in Sample #C.1 were reviewed. Three individuals in the sample had a Crisis Intervention Plan that defined the use of restraint. It is a concern that eight restraints (32%) in the sample were over 15 minutes in duration with the longest lasting 120 minutes (i.e., two hours). • Release instructions in Individual #410's crisis intervention plan instructed staff to maintain the restraint for a minimum of 15 minutes. It was not clear that he should be released prior to 15 minutes if he was no longer a danger to himself or others. The plan did not include a maximum duration for restraint as required by state policy (Use of Restraints – Policy #001.1). He was restrained on 11/19/13 for 55 minutes, on 11/14/13 for 120 minutes, and on 11/9/13 for 63 minutes. When restraints are required for an excessive duration, the restraint documentation should clearly define behaviors that indicated that he was still a danger to himself or others. Minimal narrative on the restraint checklist and FFAD made it difficult to determine if he remained at imminent danger throughout the duration of the restraint. • Individual #170's crisis intervention plan instructed staff to attempt to release him after 15 minutes. It then stated that if he struggled or displayed agitation, he should be restrained 15 more minutes. Again, it was not clear that staff should release him if he was no longer a danger to himself or others before the 15-minute time period was up. He was restrained for 60 minutes on 11/1/13. Documentation for the restraint did not include sufficient description of his behavior to determine if the continued need for restraint was justified. • Individual #301's Crisis Intervention Plan instructed staff to restrain him for a minimum of 10 minutes. There was no limit set for the maximum restraint duration as required by state policy. a. For the individuals involved in physical restraint who had a Crisis Intervention Plan (Individual #410, Individual #170, Individual #301), 19 of 21 (90%) 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. As noted above, CIPs 170 did not clearly indicate that the individual should be released when no longer a danger to himself or others. • The restraint checklist for Individual #410 indicated that he was yelling/screaming at the time of release. It did not indicate that he was no longer a danger to himself or others.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The restraint checklist for Individual #301 on /17/13 at 10:05 pm did not document his behavior at the time of release. b. For the individual who did not have Crisis Intervention Plans, three of three (100%) included sufficient documentation to show that the individual was released according to facility policy or as soon as the individual was no longer a danger to him/herself. Based on this review, the facility was in not in substantial compliance with C2. To gain compliance, the facility will need to ensure that all Crisis Intervention Plans instruct staff to release an individual from restraint when he/she is no longer a danger to himself or others.	
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 parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	a. Based on a review of 25 restraint records (Sample #C.1), in 23 (91%) there was evidence that documented that restraint was used as a crisis intervention. See C1f. b. All individuals in the sample had a Positive Behavior Support Plan in place. In review of Positive Behavior Support Plans for six individuals in the sample, 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) (100%). c. In addition, facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention, except for protective mechanical restraints for SIB. d. In 25 of 25 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list maintained by the facility. e. The facility reported that 216 restraints were used to complete routine medical appointments from 7/1/13 through 11/30/13. In 133 of 133 restraints reviewed, there was no evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list. The "Do Not Restrain" list included 12 individuals. It was not evident that all IDTs were having an adequate discussion regarding the risk of restraint for each individual. For example, • Individual #410's ISP did not document discussion regarding the risk for pretreatment sedation, even though he had a number of risks that might have impacted his safety during sedation including drug interactions and cardiac disease. He was given pretreatment sedation on 6/4/13. f. In 25 of 25 restraint records reviewed in Sample #C.1 (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing documentation from Sample #C.3 (documents II.9 and XI.27) for individuals for whom restraint had been used for the completion of medical or dental work: • g. Zero (no documentation submitted) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC)) approval and adequate consent. • h. Zero (no documentation submitted) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. • i. Zero (no documentation submitted) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility did not submit ISPs, ISPAs, or other documentation (as requested for document II.9) to determine if these requirements had been met. Based on this review, the facility was not in substantial compliance with C4. To gain substantial compliance, the facility needs to provide documentation to the monitoring team to show that the HRC has approved all medical/dental restraints prior to implementation and that the IDT has discussed the use of restraint and strategies that might reduce the need for future restraints.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a	a. Review of facility training documentation did show that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. Restraint Monitor training did include training specific to monitoring of a restraint incident. According to a list provided by the facility, all restraint monitors had recently (October 2013) been deemed competent to monitor restraints. c. Based on review of document request II.19, for staff that performed the duties of a restraint monitor for restraints, 24 (100%) successfully completed the training currently provided by the facility to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. Training occurred in October 2013. Based on a review of restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In 9 out of 25 incidents of restraint (36%) by an adequately trained staff member. These 9 were those that occurred after training in October 2013. The others occurred prior to this training. • e. In 25 out of 25 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • f. In 25 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 24 instances (92%), the documentation showed that an assessment was completed of the consequences of the restraint. The FFAD was incomplete for restraint of Individual #301 on 6/17/13 at 9:49 pm. A sample was not reviewed of PMR restraint records for which physicians had ordered alternative monitoring schedules was reviewed. None were reported by the facility. • h. In (n/a), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In (n/a), the alternative monitoring schedules were followed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	medical restraint, the physician shall specify the schedule and type of monitoring required.	Based on a review of 24 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 15 (63%) of the instance of restraint. Exceptions were: o Individual #410 on 11/19/13 o Individual #410 on 11/14/13 o Individual #410 on 11/9/13 o Individual #170 on 10/15/13 (one attempt-refused) o Individual #170 on 9/29/13 (one attempt–refused) o Individual #301 on 9/30/13 o Individual #301 on 8/18/13 o Individual #301 on 6/17/13 (x2) o Individual #469 on 11/20/13 • k. Monitored and documented vital signs in 18 (75%). The exceptions were: o Individual #410 on 11/19/13 o Individual #170 on 10/15/13 o Individual #170 on 9/29/13 o Individual #301 on 9/30/13 o Individual #301 on 8/18/13 o Individual #301 on 6/17/13 (x2) • l. Monitored and documented mental status in 23 (96%). The exception was: o Individual #301 on 6/17/13 (x2) Based on documentation provided by the facility, two restraint incidents had occurred off the grounds of the facility in the last six months. A sample of one restraint incident was reviewed (sample #C.5). • m. Conducted monitoring within 30 minutes of the individual's return to the facility in one out of one (100%). • n. Monitored and documented vital signs in one (100%). • o. Monitored and documented mental status in one (100%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. For these individuals, • p. In four out of four (100%), the physician specified the schedule of monitoring required or specified facility policy was followed; and • q. In ___ out of ___ (n/a), the physician specified the type of monitoring required if it was different than the facility policy. r. In two out of four of the medical restraints (50%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the	

#	Provision	Assessment of Status	Compliance
		physician prescribed. Exceptions were: • Individual #221 on 11/13/13 – monitoring did not begin within 30 minutes of initiation of the restraint and was not continued with the frequency ordered by the physician. • Individual #544 on 11/15/13 – monitoring did not occur with the frequency ordered by the physician. Based on this review, the facility was not in substantial compliance with this provision. To gain substantial compliance with the requirements of C5, the facility will need ensure that: 1. PMRPs are developed for individuals with protective mechanical restraints. 2. A licensed healthcare professional monitors and documents vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint. It is also recommended that the facility provide additional competency based training to all restraint monitors on the requirements of monitoring and reviewing restraints.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every	A sample (Sample #C.1) of 25 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 25 (100%), continuous one-to-one supervision was provided; • b. In 25 (100%), the date and time restraint was begun; • c. In 25 (100%), the location of the restraint; • d. In 21 (84%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. Although staff completing the restraint checklist did not typically document what was occurring prior to the behavior that led to the restraint, restraint monitors were including that information on the FFAD after interviewing staff involved. • e. In 0 (0%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. Staff completing the restraint checklist indicated that PMAB strategies and intervention strategies included in the PBSP were used prior to restraints by completing the intervention checklist on the restraint checklist. Without a narrative description of interventions on the restraint checklist or FFAD, it was not possible to determine if restraint was used as a last resort measure or if supports needed to be revised if not effective. • f. In 25 (100%), the specific reasons for the use of the restraint; • g. In 25 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • h. In 25 (100%), the names of staff involved in the restraint episode;	Noncompliance

#	Provision	Assessment of Status	Compliance
	use of restraint shall be documented consistent with Appendix A.	• Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 25 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration). The longest physical restraint in the sample was 120 minutes. o j. In six (100%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; o k. In zero of six (0%), 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. • l. In 25 (100%), the level of supervision provided during the restraint episode; • m. In 24 of 24 physical restraints (100%), the date and time the individual was released from restraint; and • n. In 25 (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 25 records (Sample #C.1), restraint debriefing forms had been completed for 24 (96%). The FFAD was incomplete for Individual #301 dated 6/17/13. p. A sample of four individuals subject to pretreatment sedation for medical treatment was reviewed (Sample #C.3), and in two (50%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. Exceptions were: • Individual #221 on 11/13/13 – monitoring did not begin within 30 minutes of initiation of the restraint and was not continued with the frequency ordered by the physician. • Individual #544 on 11/15/13 – monitoring did not occur with the frequency ordered by the physician. Sample #C.4 was a subsample of the one chemical restraints included in Sample #C.1. q. In one (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the behavioral health specialist or psychiatrist, 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 not in substantial compliance.	

#	Provision	Assessment of Status	Compliance
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 seven individuals were placed in restraint more than three times in a rolling 30-day period. This represented a decrease from the last review when 11 individuals were placed in more than three restraints in a rolling 30-day period. Three of these individuals (i.e., Individual #410, Individual #333, and Individual #301) were reviewed (43%) 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 were requested for all three individuals. The monitoring team did not receive any ISPAs for individual #301. The results of this review are discussed below with regard to sections C7a through C7g of the Settlement Agreement. LSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as noncompliance, however, because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a rolling 30-day period, and the available ISPAs did not consistently reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors and an action plan for modifying them to prevent the future probability of restraint. Individual #333's ISPA minutes did not reflect a discussion of the adaptive skills, biological/medical status, and psychosocial factors that may affect her restraints. Individual #410's ISPA minutes reflected a discussion of the adaptive skills, biological/medical status, and psychosocial factors that may affect his restraints. This discussion, however, did not reflect 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. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(b) review possibly contributing environmental conditions;	LSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as noncompliance, however, because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a rolling 30-day period occurred, and neither of the two available ISPAs reflected a discussion of potential contributing environmental factors (e.g., noisy or crowded environments). In order to achieve substantial compliance with this provision item, the minutes from 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review possibly contributing environmental conditions, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	LSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a rolling 30-day period occurred, and neither of the two available ISPAs reflected a discussion of potential antecedents to the behavior that provokes restraint. In order to achieve substantial compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review potential environmental antecedents, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	LSSLC's self-assessment indicated that this provision item was in substantial compliance. This item was rated as being in noncompliance, however, because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a rolling 30-day period occurred, and the available ISPAs did not consistently reflect a discussion of the variables potentially maintaining the behavior provoking restraints, and suggestions for modifying them to prevent the future probability of restraint. Individual #410's ISPA minutes did not reflect a discussion of potential variables maintaining the dangerous behavior that provoked restraint. Individual #333's ISPA reflected a discussion that staff attention may have maintained her physical aggression, however there was no evidence of a discussion of potential action to address this hypothesized variable (e.g., retrain staff to minimize attention, increase staff attention for appropriate behaviors, etc.) maintaining her dangerous behavior that provoked restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In order to achieve compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the variables maintaining the dangerous behavior that provokes restraint. The ISPA minutes should also reflect an action 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;	There were improvements in this item since the last review. Therefore, it is now rated as substantial compliance. 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 (100%) the type of restraint authorized was delineated, • For all three (100%) the maximum duration of restraint authorized was specified, • For all three (100%) the designated approved restraint situation was specified, and • For all three (100%) the criteria for terminating the use of the restraint were specified.	Substantial Compliance
	(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	This item was rated as substantial compliance in LSSLC's self-assessment. For none of the individuals reviewed, however, was there evidence 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). In order to achieve substantial compliance with this provision item, LSSLC needs to	Noncompliance

#	Provision	Assessment of Status	Compliance
	settings and fully as written upon each occurrence of a targeted behavior; and	ensure that at least 85% of individuals with more than three restraints in a rolling 30-day period have treatment integrity data that indicates that their PBSPs was implemented as written.	
	(g) as necessary, assess and revise the PBSP.	LSSLC rated this item in substantial compliance in their self-assessment. Only one (Individual #410) of the two ISPAs reviewed, however, documented that the PBSP was reviewed. In order to achieve substantial compliance with this provision item, 85% of the 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.	The facility had a restraint review system in place for all crisis intervention restraints. All restraints continued to be reviewed by the behavioral health specialist, unit directors, and IMRT. Errors in restraint implementation and documentation were not noted, so it was not possible to determine if corrective action was taken when errors found. For example, restraint monitors failed to document on the FFAD when monitoring by the nurse was not completed as required as noted in C5. The psychologist, unit director, and IMRT signed off on the restraint form without acknowledging errors in documentation. A sample of documentation related to 25 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 25 (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. The exceptions were (none): • b. In 25 (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. The exceptions were (none): • c. In 25 (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 25 (100%), the review conducted by the restraint monitor and/or behavioral health specialist 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. • e. The IMRT did not document recommendations from their review for any of the restraints in sample #C.1. The IMRT should document any recommendations	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		made during review of the restraint incident. The IDT, however, routinely met following restraints and made recommendations when warranted. • f. Of the ___ referred to the team, in _____ (n/a) appropriate changes were made to the individuals' ISPs and/or PBSPs. (none were referred) A review of ISPAs for the individuals in the sample indicated that IDTs routinely met following restraint episodes. Based on this review, the facility was in substantial compliance with review requirements. A review process was in place, however, the monitoring team recommends that any recommendations made during the restraint review process should be documented and tracked for follow-up.	

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:** Documents Reviewed: o Section D Presentation Book o LSSLC Section D Self-Assessment o DADS Policy: Incident Management #002.4, dated 11/20/12 o LSSLC Policy: Investigation of Client ANE revised 11/20/13 o LSSLC Policy: Incident Management revised 5/21/13 o LSSLC Procedures: Injuries to Individuals revised 12/3/13 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12 o Incident Management Review Committee meeting minutes for each Monday of the past six months o Unit Meeting Minutes for the past six months o Executive Safety Committee meeting minutes o Acknowledgement to report abuse for all employees hired within the last 2 months o Abuse/Neglect/Exploitation Trend Reports for the past two quarters o Injury Trend Reports for the past two quarters 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 6/1/13 o All injury report for the past six months for any individual sustaining a serious injury. o List of all ANE allegations since 6/1/13 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 (1) o Documentation from the following completed investigations, including follow-up:

Sample D.1.	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42944990 UIR #14-44	Emotional/Verbal Abuse (1) Physical Abuse (2)	Confirmed (1) Unconfirmed (1) Unconfirmed (1)	11/22/13 7:59 pm	11/25/13 3:40 pm	12/2/13
#42942101 UIR #14-43	Neglect (2)	Unconfirmed (1) Confirmed (1)	11/20/13 6:54 pm	11/21/13 8:42 am	11/27/13
#42934775 UIR #14-42	Neglect	Unconfirmed	11/14/13 9:26 am	11/14/13 4:50 pm	11/22/13

#42918169 UIR #14-37	Physical Abuse (2)	Unconfirmed (2)	10/30/13 11:09 am	10/31/13 3:30 pm	11/19/13
#42916492 UIR #14-36	Physical Abuse	Unconfirmed	10/29/13 10:24 am	10/29/13 3:30 pm	11/7/13
#42915100 UIR #14-35	Neglect Physical Abuse	Confirmed Confirmed	10/28/13 10:56 am	10/28/13 2:00 pm	11/7/13
#42914754 UIR #14-33	Physical Abuse	Unconfirmed	10/27/13 5:50 pm	10/29/13 3:00 pm	11/6/13
#42892763 UIR #14-29	Neglect Physical Abuse (2)	Unconfirmed Unconfirmed (1) Other (1)	10/7/13 6:35 pm	10/9/13 4:30 pm	10/16/13
#42889967 UIR #14-25	Emotional/Verbal Abuse (5)	Inconclusive (4) Other (1)	10/4/13 10:22 am	10/4/13 12:06 pm	10/14/13
#42825704 UIR #13-167	Emotional/Verbal Abuse (2) Neglect (2) Physical Abuse (1)	Confirmed (2) Confirmed (2) Inconclusive (1)	8/5/13 12:27 pm	8/6/13 2:30 pm	10/18/13
#42797788 UIR #13-147	Emotional/Verbal Abuse (1) Neglect (2) Physical Abuse (3)	Unconfirmed (1) Unconfirmed (2) Unconfirmed (2) Other (1)	7/6/13 11:34 pm	7/7/13 11:13 am	7/26/13
#42924817 UIR #14-40	Neglect	Referred Back	11/5/13 3:22 pm		11/5/13
#42871933 UIR #14-10	Neglect	Clinical Referral	9/18/13 3:27 pm		9/18/13
#42856356 UIR #14-03	Neglect	Referred back	9/4/13 5:05 pm		9/4/13
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**	**Date Completed**	
UIR #14-34	Serious Injury	10/28/13 10:15 am	10/28/13 10:20 am	11/4/13	
UIR #14-27	Serious Injury	10/7/13 4:53 pm	10/7/13 4:55 pm	10/11/13	
UIR #14-28	Serious Injury	10/7/13 5:30 pm	10/7/13 5:30 pm	10/14/13	
UIR #14-23	Choking	10/2/13 7:55 am	10/2/13 8:17 am	10/8/13	

UIR #14-11	Serious Injury	9/19/13 12:11 pm	9/19/13 12:11 pm	9/25/13	
UIR #14-1	Sexual Incident	9/1/13 9:15 am	9/1/13 9:30 am	9/9/13	
UIR #13-171	Choking	8/7/13 5:42 pm	8/7/13 6:00 pm	8/14/13	
UIR #13-163	Death	7/29/13 7:08 am	7/29/13 8:33 am	8/2/13	
UIR #13-156	Sexual Incident	7/21/13 1:57 pm	7/21/13 1:58 pm	7/26/13	

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Mike Ramsey, Incident Management Coordinator
- Robin McKnight, Director of Behavioral Health Services
- Luz Carver, QIDP Coordinator

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 1/13/13 and 1/14/13
- ISP preparation meeting for Individual #326 and Individual #502
- Annual IDT Meeting for Individual #418 and Individual #551
- Castle Pine Unit Meeting 1/14/13
- 559 Home Team Meeting 1/1/13
- Executive Safety Committee Meeting 1/16/13
- Restraint Reduction Committee Meeting

Facility Self-Assessment:

LSSLC submitted its self-assessment. Along with the self-assessment, the facility had two other 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. A sample of completed investigations was reviewed monthly using the statewide

	section D audit tool. Additionally, the facility looked at other documentation relevant to each provision. For example, for D2i, the facility had developed an audit system to ensure that all injuries were consistently documented and reported for investigation when warranted. Injury audits were reviewed for compliance with the requirement to have an adequate injury audit system in place. The facility's review of its own performance found compliance with 20 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with four of the seven provision items reviewed. The monitoring team was unable to confirm compliance with the requirements of D2i, D3i, and D4. The facility self-assessment indicated that the facility was in compliance with D2i. While the monitoring team agreed that progress had been made with this provision, the facility was not yet in substantial compliance. Ratings for D3i and D4 were similar for the self-assessment and the monitoring team's review (i.e., noncompliance). These are the two areas that will greatest additional focus in the upcoming months. The facility should note findings by the monitoring team for each provision found not to be in substantial compliance and consider further review of those provisions using similar methods used by the monitoring team.
	Summary of Monitor's Assessment: According to a list provided by LSSLC, DFPS conducted 64 investigations involving 86 allegations at the facility between 7/1/13 and 1/14/14, including 35 allegations of physical abuse, 17 allegations of verbal/emotional abuse, 2 allegations of sexual abuse, 29 allegations of neglect, and three allegations of exploitation. Of the 86 allegations, there were seven confirmed cases of physical abuse, five confirmed cases of verbal/emotional abuse, seven confirmed cases of neglect, and no confirmed case of exploitation. The facility reported that 50 other serious incidents were investigated by the facility during this period. There were a total of 1423 injuries reported between 6/1/13 and 11/19/13. These 1423 injuries included 28 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and were made available to IDTs for access on the shared drive. There were two significant areas of concern related to injuries identified by the monitoring team. • There were 407 injuries related to mobility, including falls, bumping into objects, and injuries that occurred during lifting or transferring individuals. The facility had developed corrective action plans to address the high number of falls resulting in injuries. Many of the action steps had not yet been fully implemented. The number of falls had significantly declined since the last monitoring visit, but there had been an increase in serious injuries. There were still 168 falls reported over the past two quarters. Once again, many of the serious injuries were preceded by similar incidents not adequately addressed by further assessment or a review of related data (i.e., medication changes, increases in seizures activity). • Many of the investigations in the sample involved injuries attributed to behavior of the individual(s) involved, particularly self-injurious behavior. IDTs were identifying trends in some cases and revising supports to protect individuals. QAQI Council minutes indicated that there had been a greater focus on addressing triggers for self-injurious behavior, such as lack of communication skills

	and programming based on preferences, via corrective action plans to address injuries. None of the investigations in the sample involving injuries attributed to behavior included recommendations or discussion by the IDT regarding factors contributing to the behavioral incidents. While the incident management and quality assurance departments were placing a greater focus on trends and systemic issues that contributed to incidents and injuries, it was still not evident that IDTs were proactive in revising supports and monitoring implementation following incidents. Individuals at the facility continued to remain at risk for harm due inadequate follow-up to incidents by IDTs. The facility had established an Executive Safety Committee to review trends of injuries and incidents. General recommendations were made by the committee for follow-up to issues identified. It was good to see this focus on incidents at the administrative level. The committee should consider formalizing recommendations into action plans with specific steps that could be monitored for implementation and then using data to track outcomes. The parties agreed that there be no monitoring for 15 of the 22 section D provisions that were found to be in substantial compliance during the last three or more monitoring visits. During this review, the monitoring team found the facility to be in substantial compliance with four out of seven provisions of section D that were reviewed. Provision items found not to be in compliance were: • D2i: The facility had developed an adequate injury audit process, however, was not yet implementing the process with a sufficient sample size. • D.3.i: The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring. • D.4: The facility was still not adequately developing action plans to address trends. Recommendations did not include measurable outcomes and follow-up to recommendations was not documented. The incident management department had recently begun providing incident and injury trend information to residential units and individual IDTs. The process remained in the initial stages and adequate action plans and follow-up to action plans to track outcomes were not yet occurring. IDTs will need additional training on analyzing and addressing trend information.

#	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 parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such 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. According to a list of all abuse, neglect, and exploitation investigations provided in response to document request III.TT.6, there were 64 investigations involving 86 allegations of abuse, neglect, or exploitation conducted by DFPS at the facility between 7/1/13 and 1/14/14. From these 86 allegations, there were: • 35 allegations of physical abuse including, o 8 confirmed o 20 unconfirmed o 5 inconclusive o 2 pending outcome • 17 allegations of verbal/emotional abuse including, o 5 confirmed o 9 unconfirmed o 3 inconclusive • 2 allegations of sexual abuse including o 1 unconfirmed o 1 unfounded • 29 allegations of neglect including, o 7 confirmed o 13 unconfirmed o 1 inconclusive o 8 referred back to the facility for further investigation • 3 allegations of exploitation o 3 unconfirmed.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		According to a list provided by the facility, there were 50 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 28 serious injuries/determined cause, • 1 serious injuries from peer-to-peer aggression, • 0 serious injury/undetermined cause • 2 sexual incidents, • 4 choking incident, • 0 suicide threats, • 0 encounters with law enforcement, • 0 unauthorized departures, • 3 death, and • 6 other (unknown). From all investigations since 7/1/13 reported by the facility, 23 investigations were selected for review. The 23 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 (14 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (9 cases). Metric 2.a.1: Based on the monitoring teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements. Metric 2.a.2: According to LSSLC Protection from Harm Policy, staff were required to report abuse, neglect, and exploitation immediately by calling the DFPS 800 number. This was consistent with the Settlement Agreement requirements. Metric 2.a.3: With regard to unusual/serious incidents, the facility's Incident Management Policy required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to follow reporting requirements detailed on the Exhibit B – Unusual Incidents Reporting Matrix. This policy was consistent with the Settlement Agreement requirements. Metric 2.a.4: Based on responses to questions about reporting, six of six (100%) staff responsible for the provision of supports to individuals were able to describe the	

#	Provision	Assessment of Status	Compliance
		reporting procedures for abuse, neglect, and/or exploitation. Metric 2.a.5: Based on responses to questions about reporting, six of six (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents. Based on a review of the 14 investigation reports included in Sample #D.1: • Metric 2.a.6: 14 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within one hour of the incident or discovery of the incident as required by DADS/Facility policy. One incidents were not reported within one hour of the incident, however, there was no evidence that the facility suspected abuse, neglect, or exploitation prior to the report being filed. • Metric 2.a.7: Fourteen (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o 14 of 14 (100%) indicated the facility director or designee was notified of the incident within one hour. o 14 of 14 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o 14 of 14 (100%) documented that the state office was notified as required. • Metric 2.a.8: For the allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, 0 UIRs (n/a) included recommendations for corrective actions. Based on a review of nine investigation reports included in Sample #D.2: • Metric 2.a.9: Eight (89%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. UIR #13-171 was not reported to the facility director/designee within one hour. • Metric 2.a.10: Nine (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. • Metric 2.a.11: For the unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folders did not include recommendations for corrective actions. Metric 2.a.12: 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.	

#	Provision	Assessment of Status	Compliance
		Metric 2.a.13: Based on a review of 25 investigation reports included in Samples #D.1 and #D.2, 25 (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. Sixty-one of 62 (98%) new employees hired between 10/1/13 and 11/31/13 signed this form when hired. All employees were required to sign an acknowledgement form annually. The facility was in substantial compliance with the requirements of D2a.	
	(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 6/26/13 and 11/7/13. The log included the applicable investigation case number, date of the incident, any disciplinary actions taken, and the date the employee was returned to work. Based on a review of investigation reports included in Sample D.1, in 13 out of 14 cases (93%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status immediately. The exception was DFPS case #42871933. The employee was reassigned to another home. In 11 out of 13 cases (85%), where there was a known alleged perpetrator, there was no documentary 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. • In DFPS case #42918169, the AP was returned to a position of client contact on 11/7/13. DFPS did not conclude the investigation until 11/19/13. An interdepartmental email indicated that the AP could return to work, but not at the AV's home until "everything was cleared up." • DFPS case #42871933 was referred back to the facility as a clinical issue. There was no evidence that the employee received any type of retraining or disciplinary action before returning to her position.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		In both of the above cases, however, DADS reported that neither employee was returned to work prior to a well supported determination by the facility that the AP did not pose a risk to other individuals (i.e., 5-day report that the incident did not occur, retraining and disciplinary action). The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 14 investigation files in Sample D.1, 13 (93%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, a head-to-toe assessment by a nurse, and an emotional assessment. • In DFPS case #42942101, it was noted that the individual involved had wandered off the home and fell while having a seizure on 11/20/13. The facility was aware that he was at high risk for falls and needed additional support when having seizures or walking off the home. The UIR recommended that the IDT meet to discuss his supports. There was no indication that the team met immediately or that his level of supervision was increased until the team could meet. The recommendation for the team to meet included a completion date of 12/13/13. It is a concern that immediate protections were not documented that would prevent a similar incident. All allegations were discussed in the daily IMRT meeting and protections were reviewed.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.		
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.		
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The facility policy and/or procedures (Injuries to Individuals, revised 12/3/13) defined sufficient procedures to audit whether significant injuries are reported for investigation. Metric 2.i.2: The facility conducted audits at least semi-annually, during the preceding 13 months. Twenty-eight files were chosen to be audited during the past six months. Seven record audit reviews were reviewed by the monitoring team. In these seven reviews, no significant injuries were discovered that were not reported for investigation. In regards to investigations reviewed, one incident was noted where injuries should have been reported for investigation. • Evidence in DFPS case #42918169 included reports of bruising in suspicious locations including circular bruises to the inside and outside of her upper arms, and bruising on her thighs and breast. Injury reports attributed the bruises to possible peer-to-peer aggression. There was no indication that any of the injuries were reported for further investigation. Although the bruises might have been caused by peer-to-peer incidents, due to the location and frequency, these injuries should have been reported for further investigation. The guardian had reported concerns several times regarding the frequency of bruising. The facility had implemented a plan to complete a body check prior to visits with the guardian and was documenting all injuries found during body checks, but failed to thoroughly investigate the origin of the bruises or revise supports in an attempt to protect the individual from further injury. Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. Auditors reviewed Integrated Progress Notes, Staff Observation Notes and Shift Logs, Client Injury Data Reports, Unit Meeting Minutes, and Campus Coordinator Logs for documentation of any injuries the individual might have incurred during the month reviewed. The auditor then looked for a corresponding injury report or investigation if the injury was from an unknown source or in an unusual (suspicious) location on the body. • Audits reviewed appeared to be thorough for documentation that was available, however, in four of seven of the audits in the sample, the reviewer indicated that not all records were available for review. This issue should be addressed by the facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Audits included good documentation of findings including comprehensive narratives describing findings. • Auditors included recommendations for corrective action when warranted. • An observation component was added to the audit process. Auditors were instructed to look for injuries on the individual, then check records to ensure that any identified injuries had been properly documented and reported. Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious. The facility: • Reviewed all reported injuries at the morning unit meetings and any serious injuries at the daily IMRT meeting. • Quarterly data reports were compiled to identify trends in injuries. As noted in D4, injury trends were not being adequately addressed by the facility. Sample #D.2 included investigations completed on a sample of four serious injuries. All four investigations were completed by the facility. One investigation in sample #D.1 was appropriately referred to DFPS for investigation when a suspicious injury of unknown cause was discovered. The facility investigator investigated all serious injuries. Findings were reviewed by the facility at daily IMRT meetings. Metric 2.i.4: In ___ of ___ (n/a) cases in sample #D.2, significant injuries identified by the audit that had not previously been investigated were reported to the Facility Director, and/or DFPS, as appropriate and immediately investigated. (none found) The facility had made good progress in developing an adequate injury audit system. The facility policy indicated that a sample of 72 would be selected every six months. The facility was not yet reviewing a sufficient number of individuals. Particularly, given the many concerns expressed regarding injuries and trends of injuries by the monitoring team, the facility should consider expanding the current sample in order to identify problems with reporting and following up on injuries and injury trends.	

#	Provision	Assessment of Status	Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	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 included in sample #D.1 noted the date and time of initial contact with the alleged victim. (The three investigations referred back to the facility for further review were not used in this sample). o Contact with the alleged victim occurred within 24 hours in seven of 11 (64%) investigations. Exceptions were DFPS cases #42944990, #42914754, #42892763, and #42825704. o Documentation showed 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. • For investigation in sample #D.1, eight of 11 (73%) were completed within 10 calendar days of the incident. Extensions were filed for three investigations. The investigations not completed within 10 days: o Case #42918169 was submitted on the 20th day (new witnesses were identified). o Case #42825704 was submitted on the 75th day (delayed for OIG investigation). o Case #42797788 was submitted on the 20th day (new witnesses identified) • All 14 (100%) resulted in a written report that included a summary of the investigation findings. • In seven of 14 (50%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Three of those cases resulted in a referral back to the facility for further investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2: • The investigation began within 24 hours of being reported in nine of nine cases (100%). • Nine of nine (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Seven of seven (100%) included appropriate recommendations for follow-up action to address the incident. The facility was in substantial compliance with the requirement of D3e.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(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	Metric 2.g.1: 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. Metric 2.g.2: The facility policy required that any further inquiries or deficiencies be addressed promptly.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Metric 2.g.3: The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements). • Metric 2.g.4: The facility Incident Management Review Team (IMRT) did note any problems with any of the investigations in the sample. • Metric 2.g.5: The monitoring team did not identify problems with regard to sections D.3.e, and/or D.3.f. Based on a review of the facility's IMRT data, for n/a (--%), the facility IMRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. • Metric 2.g.6: The facility returned no cases in the sample to DFPS for reconsideration, for n/a (--%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. The IMC reported that cases were returned to DFPS when the facility did not agree with findings or had further concerns. The monitoring teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. 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, • 14 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 13 (93%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. o DFPS case #42914754 was completed by DFPS on 11/6/13. The review was dated 11/18/13. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In nine out of nine investigation files reviewed (100%), there was evidence that the supervisor had conducted a 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.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	subparagraph g, for each unusual incident.		
	(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.	Metric 3.i.1: 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. Metric 3.i.2: The facility continued to track follow-up to recommendations in the daily IMRT meeting minutes. The meeting minutes included a date that recommended action was completed, but no evidence that a review was completed (to ensure protections were effective and/or continued to be implemented). A subsample of investigations was reviewed to confirm that appropriate disciplinary and/or programmatic action was taken following the investigation when warranted. This sample included a total of 10 cases: • Eight DFPS cases: #42942101, #42918169, #42889967, #42825704, #42797788, #42924817, #42871933, #42856356; and • Two facility investigations: UIR #14-34 and #14-28 Metric 3.i.3: For four out of five (80%) of the DFPS investigations (DFPS cases: #42889967, #42825704, #42797788, #42924817, and #42871933) and one of one (100%) facility investigation (UIR#14-34) reviewed in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented in the investigation file. • DFPS case #42871933 was an allegation of neglect referred back to the facility for review because clinical staff were involved. There was no evidence of an adequate review or disciplinary action taken in regards to the neglect charge against the AP in the investigation file. However, DADS reported that evidence was maintained in the nursing department. The facility should clearly note this in the investigation file. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: Metric 3.i.4: For two out of five of the investigations reviewed (40%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. DFPS case #42856356 and facility investigation #14-34 documented that recommendations were addressed by the facility. The exceptions were: • For DFPS case #42942101, the facility did not put immediate protections in place to reduce the risk of a similar incident. A finding of neglect was confirmed	Noncompliance

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		against the facility. DFPS found that support instructions conflicted and were not written clearly enough for staff to determine what supports should be in place to address the individual's risk for falls and injury. The IDT should have met immediately to revise supports. The investigation file did not include evidence that the concerns regarding the AV's supports had been addressed. • DFPS case #42918169 involved an unconfirmed allegation of physical abuse. Evidence during the investigation indicated a pattern of documented bruises and injuries to the individual. Staff also indicated that the individual was exhibiting an increase in aggression and sexually inappropriate behaviors. The investigator made a recommendation that the IDT should "evaluate the individual's behavior." The facility director recommended an updated psychological and psychiatric evaluation. The IDT met on 11/22/13 to discuss the recommendation and then determined that her assessments were current, but did note an increase in physical aggression and inappropriate sexual behaviors (ISB). The team agreed to "attempt to identify a plan to address ISB, provide training regarding boundaries, and continue to document behaviors. There was no evidence that supports were revised or that the IDT met again to evaluate the efficacy of supports. Testimony throughout the investigation indicated that the facility had an adversarial relationship with the guardian. The facility did not address this concern. Action should be taken to try to resolve any conflicts between the guardian and the facility to establish a relationship that is in the best interest of the individual. The facility had recently restricted visits and phone calls with the guardian even though evaluations and a court order prior to admission acknowledged that the AV's relationship with her guardian was important to her. • UIR #14-28 included a recommendation for a PT assessment for Individual #517 after he sustained a serious head injury resulting from a fall. The assessment was not completed until 17 days after the fall. Metric 3.i.5: For zero out of 10 investigations (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The facility did not have a system to track outcomes from investigations. Based on identified issues with the implementation of recommendations and desired outcomes, the facility remained out of compliance with this provision.	

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	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	Metric 4.1: 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: • Metric 4.2: Were conducted at least quarterly; • Metric 4.3: Did address the minimum data elements; • Metric 4.4: Did use appropriate trend analysis procedures; • Metric 4.5: Did not provide a narrative description/explanation of the results and conclusions; and • Metric 4.6: Did not contain recommendations for corrective actions. Metric 4.7: Based on a review of trend reports, IMRT minutes, and QAQI Council minutes, when a negative pattern or trend was identified, corrective action plans (CAPs) were not always developed. The QAQI Council had CAPs in place regarding falls and injuries. It was difficult to determine what specific action had been implemented, how it was being monitored, and what data were used to determine the efficacy of the plan. Metric 4.8: As appropriate, corrective action plans were not always developed both for specific individuals and at a systemic level. None of the investigations in the sample reviewed demonstrated that when a trend of similar incidents or injuries was identified, an adequate corrective action plan was developed and outcomes were tracked. Metric 4.9: The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion.	Noncompliance

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		Metric 4.10: The trend reports/minutes did not review, as appropriate, the effectiveness of previous corrective actions. Based on a review of resulting action plans included in quarterly trend reports and documentation related to implementation: Quarterly trend reports did not include action plans with specific outcomes related to trends identified. • Metric 4.11: Zero action plans included in the quarterly trend report (0%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. • Metric 4.12: For zero of the action plans reviewed (0%), the plan had been timely and thoroughly implemented. • Metric 4.13: For zero action plans (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. To move forward, the facility will need to ensure that as trends are identified, 1. Measurable outcomes and action steps are developed; o The monitoring team recommends ensuring that unit directors are involved in the identification of trends, in the development of action plans, and in the implementation and reporting of actions. 2. Specific staff are assigned to monitor and document implementation; and 3. A date is set to review efficacy of the plan and make revisions when needed.	
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	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.		

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, updated 5/22/13 with new DADS administrative staff names o LSSLC facility-specific policies (none reviewed): o LSSLC organizational chart, undated, but likely November 2013 o LSSLC policy lists, 11/26/13 o List of typical meetings that occurred at LSSLC, undated but likely November 2013 o LSSLC Self-Assessment, 12/30/13 o LSSLC Action Plans, 12/28/13 o LSSLC Provision Action Information, 12/16/13 o LSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/13/14 o LSSLC DADS regulatory review reports, July 2013-November 2013 o List of all QA department staff and their responsibilities, November 2013 o LSSLC QA department meeting notes, (none held) o LSSLC data listing/inventory, hard copy, 11/19/13 o LSSLC data listing, process/outcome version, 11/19/13 o LSSLC QA plan narrative, (none) o LSSLC QA plan matrix, 11/22/13 o QAQI Council presentation schedule o Set of blank tools used by QA department staff (2) o Sets of completed tools used by QA department staff (none) o Sets of graphs of the QA department activities (none) o Trend analysis report, for four components, last two quarters, (through 11/30/13) o Monthly QAD-SAC-1:1 meetings (none held) o LSSLC QA Reports, (none done) o QAQI Council minutes, at least monthly July 2013 to January 2014 (6 months, 9 meetings) • Handouts and agenda for meeting during onsite review, 1/15/14 o PIT, PET, work group reports (none provided) o LSSLC Corrective Action Plan documents • 11 CAPs database tables • CAP tracking sheet (none) o Facility newsletters, The Pine Bark, Spring 2013, Fall 2013 <u>Interviews and Meetings Held</u>: o Paula McHenry, Director of Quality Assurance o Gale Wasson, Facility Director

	o Residential Director and Unit Directors: Keith Bailey, Rotley Tankersley, Kenneth Self, Todd Miller, Mary Stovall <u>Observations Conducted</u>: o QAQI Council meeting, 1/15/14 o Morning unit meeting, Castle Pines, 1/16/14 o IMRT, 1/15/14 o Medication variance committee, 1/15/14 o Clinical services meeting, each morning
	Facility Self-Assessment The QA director continued to improve upon the self-assessment in that 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 continued to be in line with the monitoring team's. The self-assessment contained a lot of detail about QA program activities. This was helpful to the monitoring team in understanding how the self-assessment was conducted, as well as provided an occasional piece of information that was not in any of the other documentation reviewed by the monitoring team. The facility self-rated itself as being in noncompliance with all sections E1, E2, E4, and E5. The self-rating for E3 was substantial compliance. The monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for four of the five provisions of section E (i.e., all except E3) because the facility had made limited progress. The noncompliance finding from the last review stands for each of these four provisions. Even so, the QA program made progress in some areas. There was not yet a complete and adequate data list inventory at the facility, though the format and organization had improved. 16 of the 20 provisions of the Settlement Agreement (80%) were included. There were a number of other data sets that were in existence or were being developed, but were not a part of the QA program, such as the key indicators described in the previous report and a new G1 project. Data from 8 of the 20 (40%) sections of the Settlement Agreement were summarized and graphed (C, D, F, K, M, O, S, T). There was, however, no consistency in presentation of data, and most did not show trends over time, or analyze data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals.

	The facility was not holding regular meetings between the QA department and the discipline departments. The monitoring team suggests that the facility determine what forum or mechanism will be used for the QA department to work directly with department heads to support and review their implementation of QA processes. There were no QA reports. Some data were presented at QAQI Council. The monitoring team reviewed these; they were attached to the QAQI Council minutes. Much work was done to improve the corrective action system. A detailed spreadsheet database system was created, with a separate spreadsheet for each CAP. There were 11 CAPs. All appeared to appropriately address the specific problem for which they were created. There were CAPs for 4 of the 20 Settlement Agreement provisions. Not every provision will always require a CAP, but at LSSLC, not all departments were participating in the CAPs system. Each CAP had additional steps added subsequent to initiation of the CAP and its first set of action steps. These additions could be considered modifications of the CAP, but it the reason for the additions were not stated.

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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 parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. Even so, the QA program made progress in some areas. <u>Policies</u> a. 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, #003.1: Quality Assurance, dated 1/26/12. The monitoring team's comments on the state policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated two years ago, edits may be needed. State office should consider this. b. There were not LSSLC facility policies that adequately supported the state policy for quality assurance. Facility policies for quality assurance were being updated, but were not yet finalized. Most recently, updates included additional information regarding corrective action plans. <u>Quality Assurance Data List/Inventory</u> c. There was not yet a complete and adequate data list inventory at the facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The data list inventory was 61 pages long, contained 27 topic areas (some were not Settlement Agreement related), and was managed in a database. 16 of the 20 provisions of the Settlement Agreement (80%) were included. There was nothing for sections G and H. Section C-related items were present, but were inserted within a number of other topic areas. Section I was called Risk Management, but the content did not address anything in the Settlement Agreement's section I. Sections O, P, and R were addressed in a single section. Of the 16 inventories, 16 (100%) included data that could be used to identify trends as required in the wording of section E1; 4 (25%) included a wide range of data; 16 (100%) included what appeared to be key indicators; 16 (100%) described the data being collected; and 3 (19%) included a self-monitoring tool (or indicated that a self-monitoring tool was not used, with a rationale). The facility recently began a process to improve the data listing inventories. Each inventory was now reviewed every quarter when that section leader was scheduled to make his or her presentation to QAQI Council. The QA director gave the data listing to the section leader to review. Instead, the data listings should be presented to QAQI Council (perhaps semi annually) so that QAQI Council can see the full list of what's being collected, as well as see if there's any duplication (this was noted in the self-assessment, but was not yet occurring). During this presentation, the monitoring team suggests that the QA director focus upon ensuring that the content is complete, items are described adequately, and that the data are being directed to the categories in the Settlement Agreement's wording of section E1. This is important to do because LSSLC was not conducting QAD-SAC 1:1 meetings. Some additional comments on the QA data listing inventory: • The presentation/database was very clear and showed good effort by the QA director. • The listing included labeling of each item as a process or an outcome indicator. They were all, however, labeled as process indicators (except for 3). As the lists develop, more consideration should be given to outcome indicators, too. • There were a number of other data sets that were in existence or were being developed, but were not a part of the QA program (i.e., data listing inventory, matrix, QA report, QAQI Council presentations). The QA director should incorporate these into the data listing inventory (and the QA matrix as appropriate). By incorporating these data into the QA program, and reviewing them regularly, problems are more likely to be identified and actions taken to address them, especially given the medical and physical demographics of the	

#	Provision	Assessment of Status	Compliance
		individuals who live at LSSLC. o key indicator work from last time o the section G1 project o Work groups/committees: such as pretreatment sedation and pneumonia (when that committee is re-started) o Scabies o Flu o Facility director periodic meetings with section leaders (described in self-assessment for E1, item 6). o A set of data in the 10/9/13 QAQI Council minutes attachments. It was not clear what these data were from, for, or how they related to the QA program. o There may be relevant data from: ▪ Unit director daily morning meetings ▪ Morning clinical services meetings ▪ IMRT meetings ▪ Medication variance meetings • The QA department did not have or keep data on section/discipline participation in QA activities (e.g., data listing, matrix, presentations, analysis, etc.). • Some single items in the inventory contained multiple items within them; this should be clearly delineated so that the reader understands what data were being collected by the department. For example, single items referred to as audits or databases in section F, J, M, and S apparently included other sets of data within them. d. The data list inventory was current. Each list was noted to have been updated on 11/19/13. That is, even though more work was needed on the content, a review and update date within the last six months was included for each section. The QA director should, however, put the update date for each list separately, when they're reviewed and updated by the department head and QAQI Council. It is unlikely that all of these were reviewed and updated on the same date. <u>Quality Assurance Plan Narrative</u> e. The QA plan narrative was not current, complete, and adequate. At some point, the QA plan narrative, if thorough, might be considered to be a facility-specific policy. <u>QA Plan Matrix</u> The QA plan matrix should contain the data from the data list inventory that are to be submitted to the QA department; these data are then included in the QA reports and	

#	Provision	Assessment of Status	Compliance
		presented to the QAQI Council. LSSLC had a QA plan matrix. The monitoring team reviewed the November 2013 QA matrix. The LSSLC QA plan matrix was nine pages long. It was well organized and the items lined up with the data listing inventory, but did not line up with the QA reports (because there were no QA reports), and did not line up with the content presented to the QAQI Council. Overall, the facility was beginning to use the QA matrix as it was intended, that is, to be a subset of the data listing, such that it correctly shows which data are to be presented in the QA report and to QAQI Council along with more detail on how the data were to be collected, reviewed, and managed. Of course, the QA matrix can only be as good as the data listing inventory. Therefore, as that improves, so may the QA matrix, QA reports, and presentations to QAQI Council. f. There were items in the QA plan matrix for 17 of the 20 sections (85%). However, for the 20 sections of the Settlement Agreement, a set of key indicators was included for n/a of the 20 (n/a%). A rating of whether these items were key important indicators was not made by the monitoring team because it was clear that the facility and the department heads were just beginning to put together thorough data listing inventories, which are needed in order to have the QA matrix describe the important key indicators for each section. g. Of the 17, both process and outcome indicators were identified for 1 of the 20 (5%) in the QA matrix. The monitoring team was impressed, however, to see the QA director and the departments identifying whether indicators were process or outcome indicators. Almost all of the indicators were labeled as process as indicators. This should continue to be addressed and will likely lead to a better set of data for the listing inventory and the matrix. h. Similarly, of the 17, in 17 (100%), the indicators provided data that <u>could be</u> 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, for each section, perhaps in her own notes, how data <u>were being</u> collected and presented to identify trends across the variables described in the wording of E1. i. The QA matrix did not include all self-monitoring tools/self-monitoring procedures. It should 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 along with a rationale). The QA matrix listed what appeared to perhaps be self-	

#	Provision	Assessment of Status	Compliance
		monitoring tools for self-monitoring tools for 4 of the 20 sections (20%). These were sections F, J, L, and S. j. All data that QA staff members collected were not listed in the matrix. At LSSLC, this was described as two tools: the risk threshold tool, and the new G1 tool. The risk threshold data item was listed under the QA section of the matrix, but the E2 self-assessment indicated that it would be part of section I. The G1 tool was not listed anywhere. k. All of the items in the QA matrix did also appear in the QA data list inventory. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. Given that the QA matrix was not yet a functional/useable tool, the following four metrics could not be rated. For the next review, the QA director should indicate which of the items in the QA matrix were: l. Submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., at least once each quarter). m. Reviewed or analyzed by the QA department and/or the department section leader. n. Conducted/implemented as per the schedule. o. Received QA department assistance in analysis of data, or if there was no assistance provided, there was documentation that it was not needed. <u>Self-Monitoring Tools</u> 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: p. 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. q. 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. r. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix.	

#	Provision	Assessment of Status	Compliance
		s. 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.	
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.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. a. Data from 8 of the 20 (40%) sections of the Settlement Agreement were summarized and graphed (C, D, F, K, M, O, S, T). There was no consistency in presentation style across these 8 sections and most did not show trends over time, or analyze data (or present data) across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. To make this determination, the monitoring team based upon a review of the minutes of QAQI Council meetings and attachments to the QAQI Council minutes (there were no QA reports) for meetings from mid-July 2013 to the meeting observed by the monitoring team during this onsite review (i.e., mid-January 2014). <u>Monthly QAD-SAC meeting with discipline departments</u> The facility was not holding these meetings. The monitoring team suggests that the facility determine what forum or mechanism will be used for the QA department to work directly with department heads to support and review their implementation of QA processes. Thus, the monitoring team was unable to rate the following metrics. b. Since the last onsite review, a meeting occurred at least twice for xx of the xx (xx%) sampled sections of the Settlement Agreement, and all five topics below were conducted during xx of the xx (xx%) meetings that occurred. • 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. c. Since the last onsite review, during xx of the xx (xx%) meetings, data were available to facilitate department/discipline analysis of data. d. Since the last onsite review, during xx of the xx (xx%) meetings, data were reviewed	Noncompliance

#	Provision	Assessment of Status	Compliance
		and analyzed. e. 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; or an indication was noted that a corrective action plan was not needed. <u>QA Report</u> f. 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%). g. Of the 20 sections of the Settlement Agreement, 0 (0%) appeared in a QA report at least once each quarter in the last six months. • Based upon a review of the attachments to the QAQI Council minutes, 1 of the 20 (5%) appeared in both quarters. 9 others (45%) appeared once. h. Of the 11 sections of the Settlement Agreement that were presented quarterly, (0%) contained all of the components listed below. The presentation of data, graphs, and information was very different across these sections. There did not appear to be any standard or expectation of what a section leader should present, how graphs should be created, if trending was required, if analysis was to be done, etc. • 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 <u>QAQI Council</u> 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 the monthly QAQI Council meetings from mid-July 2013 through mid-January 2014 (9 meetings). i. There was not an adequate description of the QAQI Council in the QA plan narrative or in a separate QAQI Council policy or procedure document. j. Since the last onsite review, the QAQI Council did meet at least once each month.	

#	Provision	Assessment of Status	Compliance
		k. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. l. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. m. Minutes (and attachments/handouts) from 0 (0%) of the QAQI Council meetings since the last review documented that (a) data from QA plan matrix (indicators, self-monitoring) were presented, (b) the data presented were trended over time and (c) comments and interpretation/analysis of data were presented. Section K was the best example. As noted above in metric h., there was no standard expectation for presentation content of format. For example, at the meeting observed by the monitoring team, three sections made presentations. All three were very good presentations (they are listed below), but they were very different from one another. The monitoring team does not wish to discourage the creativity of the presenters, but some standard expectations should be set, such as including key indicators, self-assessment data, data that show trends over time, and including everything that is in the QA matrix. • Section R: case study of one individual, an excellent, professional presentation, included data and videos. It was very interesting. • Section K: each Settlement Agreement provision was presented, most with data, all with narrative analysis and explanation. This was also done in a professional manner. • Section J: the presenter went through each of the 15 provisions of this section with narrative analysis and reference to data when there were data to discuss. n. Minutes from 0 (0%) QAQI Council meetings since the last review reflected if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. <u>Corrective Actions</u> Much work was done to improve the corrective action system. A detailed spreadsheet database system was created, with a separate spreadsheet for each CAP. At this time, there were 11 CAPs. Four were continuing from the time of the last review (i.e., were not completed) and seven were new. Each CAP included a set of action steps. Updates were provided on each action step. Action steps were added, as needed. o. An adequate written description did not exist that indicated how CAPs were generated, including the criteria for the development of a CAP.	

#	Provision	Assessment of Status	Compliance
		p. Therefore, when considering the full set of CAPs, the monitoring team could not determine if they were chosen following the written description, policy, or procedure. • Some training and discussion activities had occurred during the QAQI Council meeting on 11/13/13. • There were CAPs for 4 of the 20 Settlement Agreement provisions. Not every provision will always require a CAP, but at LSSLC, not all departments were participating in the CAPs system. q. Of the 11 CAPs reviewed by the monitoring team, 11 (100%) appeared to appropriately address the specific problem for which they were created. Based on these 11 CAPs: r. 11 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. s. 11 (100%) included the anticipated outcome of each action step. • But, there were no specific criteria to judge if the outcome was met (i.e., 0%). This should be corrected. t. 11 (100%) included the job title and name of the person(s) responsible. u. 11 (100%) included the time frame in which each action step must occur (i.e., a due date).	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the 11 CAPs, which represented 100% of the total: a. 11 (100%) included documentation about how the CAP was disseminated b. 11 (100%) included documentation of when each CAP was disseminated, and c. 11 (100%) included documentation of to whom it was disseminated, including the names and titles of the specific persons responsible.	Substantial Compliance
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 parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance

#	Provision	Assessment of Status	Compliance
	the problems originally identified.	The sample of 11 CAPs appeared to have been implemented (100%). a. Based on a sample of 0 completed CAPs and 11 in-process CAPs, n/a (--%) were implemented fully and n/a (--%) were implemented in a timely manner. The monitoring team could not determine that all aspects of CAPs were implemented fully and in a timely manner. To address this, the QAD might indicate status on the spreadsheet. That is, for each CAP (and for each action step), indicate whether it was implemented in a timely manner, done fully, and modified if needed (this last variable is for section E5). b. There was not an adequate system for tracking the status of CAPs. Of the 11 CAPs being tracked by the facility, 0 (0%) indicated the status of the CAP and any action taken if a CAP had not been implemented. Some running commentary on the status of the overall CAP should be included. However, the spreadsheet did include QAD comment on the status of many action plans. This was good to see. c. The facility QA director did maintain summary information/data regarding CAPs and their status (regarding open or closed, and status of action steps) that was updated within the month prior to the onsite review. It was on a two page spreadsheet. d. The QA director or section leader did present this information to QAQI Council at least quarterly. The monitoring team has recommended that the QA director maintain and graph some simple data on CAPs/action plans. Some data were being reported in table format. This was a good start. These data can be part of the section E data list inventory and possibly the QA matrix, too.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. a. For 0 out of 11 CAPs (0%), documentation showed review of their effectiveness (i.e., outcomes), and for 0 out of 11 CAPs (0%), documentation showed review of their timely completion. b. Of the n/a CAPs that appeared to need modification, n/a (--%) were modified. Each CAP had additional steps added subsequent to initiation of the CAP and its first set of action steps. These additions could be considered modifications of the CAP, but it	Noncompliance

#	Provision	Assessment of Status	Compliance
		the reason for the additions were not stated. c. Based on a sample of 0 completed CAPs and 11 in process CAPs, n/a (--%) were discussed at QAQI Council. CAPs were discussed at QAQI Council meetings, but the monitoring team was unable to determine which ones were discussed at which meetings. d. For n/a out of n/a (--%) modified CAPs, evidence was present to show timely implementation. e. For n/a out of n/a (--%) modified CAPs, evidence was present to show full implementation.	

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 Curriculum used to train staff on the ISP process o LSSLC Section F Presentation Book o LSSLC Self-Assessment o Monitoring tool used to assess the quality of the ISP and the ISP meeting o List of all QIDPs and assigned caseload o A list of QIDPs 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 #418, Individual #410, and Individual #551 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #11, Individual #599, Individual #43, Individual #345, Individual #74, Individual #458, Individual #518, Individual #117, Individual #556, Individual #110, Individual #401, Individual #511, Individual #522, Individual #410, Individual #170, Individual #368, Individual #101, Individual #337, Individual #555, and Individual #494 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, behavioral health specialists, and QIDPs in homes and day programs; o Robin McKnight, Director of Behavioral Health Services o Luz Carver, QIDP Coordinator o Mike Ramsey, Incident Management Coordinator o Gail Husband, Assistant Director of Programs o Rick Savage, DADS Consultant <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 1/13/14 and 1/14/14 o ISP preparation meeting for Individual #326 and Individual #502 o Annual IDT Meeting for Individual #418, Individual #410, and Individual #551 o Castle Pine Unit Meeting 1/14/14 o 559 Home Team Meeting 1/16/14

	o Executive Safety Committee Meeting 1/16/14
	Facility Self-Assessment: LSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 12/30/13 with recent activities and assessment outcomes. The QIDP Coordinator was responsible for the section F self-assessment. LSSLC continued to use the statewide section F monitoring tool to assess compliance with section F. 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. These are the same type of activities that the monitoring team looks at to assess compliance. The facility self-rated itself as being out of compliance with all provision items in section F. Findings for provisions that were audited by the facility were similar to findings of the monitoring team. For example, the monitoring team and the facility each found problems with meeting attendance, timely submission of assessments, and ensuring that action plans were developed to address assessment recommendations.
	Summary of Monitor's Assessment There was progress evident with the ISP process. At three ISP meetings and two pre-ISP meetings observed by the monitoring team, progress was noted in these areas: • The facility had received intensive training from a consultant provided by the state on the ISP development process. ISP facilitators had been trained to lead annual ISP meetings. This was a very new process and not all facilitators were competent yet in leading the meetings. This should have a positive impact on ensuring that annual ISP meetings result in comprehensive, integrated plans. • There was improvement in the risk discussions in regards to having data and assessment information that would aid in the risk discussion entered into the IRRF and available to all staff for review. • Assessment information was being used by the teams to develop outcomes based on preferences and identified needs. • There was better discussion occurring at the pre-ISP planning meetings. At both meetings, there were many good examples of integrated discussion regarding developing supports. • While some teams were still very focused on what the individual was currently doing and what supports had historically been provided at the facility, other teams were starting to brainstorm on ways to expand those opportunities and support individuals to become more independent and experience new things. IDTs observed 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 are available to all team members for review. • The facility needs to track submission of assessment by discipline prior to the annual ISP meeting and address any trends of late submission with the specific department responsible for submission. • IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection. • Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs. • 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. Likewise, data collected regarding incidents, injuries, and illnesses should be used to alert the IDT that supports are either not being implemented or are not effective and should be revised.

#	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 and two pre-ISP meetings. The ISP facilitator facilitated the annual IDT meetings. The assignment of ISP facilitators to lead the discussion was a new process for the IDTs. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, the CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last six QIDP monthly reviews, the individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation, as available. A sample was requested of the most recently developed ISPs from each residence on campus, and 10 were submitted for review. A variety of QIDPs and interdisciplinary teams (IDTs) responsible for the development of the plans were sampled. The facility was not assessing QIDPs for competency in facilitation skills. Training had recently been provided to ISP facilitators on meeting facilitation by an outside	Noncompliance

#	Provision	Assessment of Status	Compliance
		consultant. As noted above, this was a new process for the facility. The ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the ISP facilitators in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the ISP facilitators used this template to draft portions of the ISP prior to the meeting. The facilitators 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 QIDP at the annual IDT meeting. QIDPs were in attendance at all annual meetings in the sample reviewed. QIDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found the QIDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. While the facility was in substantial compliance with the requirement that one person on the IDT facilitate development of an ISP, the facility did not have an adequate monthly review process in place to ensure that plans were updated when regression or lack of progress towards outcomes was noted or when outcomes had been completed. To move forward, the facility needs to focus on ensuring that all QIDPs are competent in meeting facilitation skills. Then, ensure that QIDPs are monitoring progress/regression and revising supports and services when needed. The facility will need to demonstrate that QIDPs were taking action when the monthly review process or other data note a lack of implementation, change in status, or a lack of progress.	
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 #004.1 described the Interdisciplinary Team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, 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 pre-ISP process to identify assessments to be completed prior to the annual ISP meeting. The facility was tracking data on attendance at IDT meetings. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for August 2013-October 2013.	Noncompliance

#	Provision	Assessment of Status	Compliance

Team member	Attendance
Individual	85%
Family/Advocate/LAR	48%
DSP	86%
QIDP	100%
Psychologist	72%
RN	97%
Occupational Therapist	59%
Physical Therapist	60%
Speech Therapist	36%
Audiologist	0%
Dietician	7%
Primary Care Provider	46%
Psychiatrist	68%
Dental Services	11%
Vocational Services	100%
Active Treatment Staff	100%

Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified as relevant participants in six of six (100%) of the annual meetings in the sample. The sample included Individual #345, Individual #11, Individual #43, Individual #117, Individual #458, and Individual #599.

- At the annual ISP meeting for Individual #345, relevant team members identified at the pre-ISP meeting that did not attend the meeting included the individual, her family/LAR, the DSP, PT, dietician, PCP, and day program staff.
- Key team members not in attendance at Individual #11's annual ISP meeting included her family, behavioral health specialist, OT, SLP, and day programming staff.
- Key team members not in attendance at Individual #43's annual ISP meeting included the individual, her family, and her OT.
- Individual #117's family did not attend the meeting in person or by phone. Additionally, his SLP and social worker did not attend his meeting.
- Individual #599's behavioral health specialist, OT, and social worker did not attend his annual ISP meeting.
- Individual #458's family, behavioral health specialist, and dietician did not attend her annual ISP meeting.

In the four of the five ISP related meetings observed during the week of the monitoring visit, there was no participation by the individual. Additional effort needs to be made to ensure that each individual is a part of the planning process.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process. Relevant team members should be identified at the pre-ISP meeting, then the facility should use that information to track actual attendance by relevant team members at the ISP meeting.</td><td></td></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 #004.1 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration.

The facility had just begun gathering data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of discipline specific assessments for October 2013 indicated that assessments were not routinely submitted prior to ISP planning meetings. The chart below shows assessment submission rates for that time period.

<table>
<tr><td>Discipline</td><td>Submitted</td><td>Submitted on time</td></tr>
<tr><td>Medical</td><td>95%</td><td>54%</td></tr>
<tr><td>Psychiatric</td><td>100%</td><td>83%</td></tr>
<tr><td>Nursing</td><td>100%</td><td>95%</td></tr>
<tr><td>Dental</td><td>100%</td><td>95%</td></tr>
<tr><td>QDRR</td><td>49%</td><td>5%</td></tr>
<tr><td>Psychological</td><td>90%</td><td>77%</td></tr>
<tr><td>Habilitation Therapies</td><td>83%</td><td>6%</td></tr>
<tr><td>Nutrition</td><td>92%</td><td>5%</td></tr>
<tr><td>Vocational</td><td>No data</td><td>No data</td></tr>
</table>

The habilitation therapy department was gathering data on the timely submission of assessments. The assessment tracking log submitted indicated that for ISPs dated 7/1/13 through 2/27/13, only 50% of the assessments were performed on, or prior to, the designated due date.

As described in Section R, only 17% of individuals listed in the Master Plan had been provided a comprehensive communication assessment. Eleven others had been screened for communication needs, though this had been provided to only 50% of the individuals newly admitted to LSSLC since 6/1/13. There were only 12 individuals listed as provided an annual communication assessment between 7/23/13 and 11/18/13. Of those listed, only six had been completed on time, or within 10 days prior to the ISP. Four others were submitted via ISPAs rather than at the time of the ISP. Each of these was also considered by the monitoring team to be delinquent as they each had a previous ISP for which no communication assessment had been submitted.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. The sample included Individual #345, Individual #11, Individual #43, Individual #117, Individual #458, and Individual #599. Zero (0%) of six individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. The following table represents findings by discipline from that review.	

Assessment	Timely Submission Rate
Medical	84%
Audiology	33%
Dental	100%
Nutritional	67%
OT/PT	84%
Speech	67%
Nursing	100%
Pharmacy	84%
Psychiatry	100%
Psychology	100%
Vocational	84%
Functional Assessment	100%

The facility continued to utilize the Functional Skill Assessment (FSA). In the sample reviewed, the assessment was not always updated prior to the annual ISP meeting. In most cases, it was completed as a checklist without a summary or recommendations that would guide the team in developing training outcomes (also see section S1). 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 list of preferences and strengths for each individual was fairly comprehensive and appeared to be based on assessment 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

1. 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

#	Provision	Assessment of Status	Compliance
		facilitate adequate planning.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As described in F1c, assessments required to develop an appropriate ISP meeting were not always done in time for IDT members to review each other's assessments prior to the ISP meeting. There had, however, been progress made in integrating assessment recommendations into support plans when available to the team. QIDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and then information from assessments is used to develop plans that integrate all supports and services needed by the individual. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that assessments are completed prior to the annual ISP meeting and all recommendations from assessments are used to develop and revise supports as needed.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	DADS policy mandated that a Living Options discussion 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. As part of the ISP process, each discipline was now required by state policy to include, as part of the pre-ISP assessment process, an explicit determination of whether or not needed supports could be provided in a less restrictive setting and whether the individual should be referred for transition. Assessment templates had been revised to include a living determination statement. A majority of the assessment completed in the past six months included this statement. Examples of assessments that did not include this statement were: • Individual #458's vocational and nutritional assessments; • Individual #74's dental and psychological assessments; • Individual #11's dental, nutritional, and residential assessments; • Individual #555's psychological, dental, and vocational assessments; and • Individual #518's psychiatric, dental, and nutritional assessments. In the new ISP format, discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with a consensus opinion by team members from various disciplines. Any barriers to community placement were to be addressed in the ISP. See section T regarding the quality of discipline specific determinations. At annual ISPs observed for Individual #551, Individual #410, and Individual #418, team members discussed living options. • Individual #551's LA led the discussion on living options. The ISP facilitator did	Noncompliance

#	Provision	Assessment of Status	Compliance
		not seek input from all team members regarding whether or not supports could be provided in a less restrictive environment. The only barrier to community placement discussed was the reluctance of her advocate to consider other living options. The team did not develop an adequate plan to address this barrier. • The QIDP summarized living options for Individual #410. Little input was provided by other team members. They all agreed that at this time, supports could not be provided in a less restrictive setting. The team identified his behaviors as a barrier to living in a less restrictive setting and needed supports were discussed by the team. • Individual #418's team held a better discussion of living options. The IDT had identified his limited exposure to the community as a barrier at his previous ISP meeting. The DSP did a nice job of describing his response to community outings that the team had planned for increased exposure in the community over the past year. The team agreed that he could be supported in a less restrictive environment, but acknowledged that further exposure to the community would be beneficial. They agreed to refer him to the transition house for placement while continuing to expose her to new experiences in the community. Vocational staff discussed the importance of work in his day and talked with the team about options for community employment. The team agreed to provide more opportunities for exposure to community employment during the upcoming year. There was little focus on providing additional opportunities for individuals to participate in day programming in the community. The facility did not have options for individuals to receive day habilitation in the community. Minimal formal training was occurring in the community. Ten ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #518, Individual #555, Individual #337, Individual #117, Individual #74, Individual #458, Individual #599, Individual #345, Individual #43, and Individual #11. Four (40%) of the ISPs included meaningful training opportunities in the community. Community based outcomes for most individuals 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 #518 had community based outcomes to attend community outings twice per month, attend the rodeo, and attend a church in the community. The outcome did not describe specific training to be provided in the community. • Individual #117 had outcomes to go on community excursions and go out to eat for his birthday.	

#	Provision	Assessment of Status	Compliance
		ISPs that included specific measurable training objectives to be implemented in the community: • Individual #555 had an outcome to work on the mobile work crew in the community. • Individual #458 had an outcome to go shopping to purchase an item of her choice. • Individual #345 had outcomes to purchase magazines and hair accessories in the community and complete a Build-A-Bear project for her collection. • Individual #42 had an outcome to learn to exchange money for items of her choice in the community. There was no focus on providing supported employment or volunteer opportunities for individuals at the facility. The facility reported 114 individuals involved in vocational programs. Of the 114, two (1.7%) individuals participated in supported employment in the community. The sheltered workshop should be a job training site with a goal to support individuals to work in the community. The vocational program did not provide training focused on community employment. Only one of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed,	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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	identifies the supports that are needed, and encourages community participation;	In the ISP meetings observed, IDTs engaged in a much better discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting, and developed plans to include the individual's preferences throughout the day. Teams were beginning to use preferences to build new training opportunities for individuals. This was particularly evident at the two pre-ISP meetings observed. IDTs, however, were still not discussing how to minimize risks in relation to the individual's preferences and interests. Lists of preferences in the ISPs in the sample reviewed included a broad range of activities and were individual specific. IDTs, however, 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. Preferences were used to develop outcomes for participation in preferred activities, but training was not based on preferences in the ISPs reviewed. 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 specific interests, or exploring volunteer or work opportunities. In a review of 10 recent ISPs, four (40%) 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. As noted in F1e, outcomes for training offered opportunities for visits in the community, but few were focused on gaining specific skills. IDTs did little to develop community integration strategies that included the 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 focus 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	A sample of ISPs, IHCPs, 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 facility had made progress on the development of measurable outcomes,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	particularly in regards to those outcomes addressed with a skill acquisition plan. Additionally, there were improvements in developing measureable outcomes to address risks in IHCPs. As noted in F1e, only 40% of the ISPs reviewed included measurable outcomes to address barriers to community placement. The monitoring team found that there were still outcomes not written in a way that staff could measure progress towards completion or plans did not provide enough information to ensure consistent implementation. None (0%) of the plans in the sample included a full array of measurable outcomes. For example: • Individual #458 had an outcome to "continue to work at the workshop." There were no staff instructions to indicate what type of work she would do, what training would occur, what supports would be needed, or what barriers might need to be addressed. There was not enough information to ensure consistent implementation. Outcomes in her IHCP that were not measureable included outcomes to monitor her blood pressure, report signs of pain, and assess for abdominal distention (no parameters given). • Individual #74 had an outcome to continue formal training during work. Again, there were no instructions on how staff should implement the outcome and what criteria would be used to determine progress or regression. Another outcome stated that he would participate in an activity for exercise. The outcome did not indicate what level of participation would be considered a successful attempt, what level of support that staff would need to provide or barriers might need to be addressed. His IHCP included outcomes to monitor his blood pressure and weight. An acceptable range was not stated for either outcome. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Sections M and 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The development of action plans that integrated all services and supports was still an area with which the facility struggled. 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. As noted in F1d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. All of the SAPs in the sample reviewed incorporated individualized strategies developed using therapy and behavioral assessments available at the time of development. As noted, many assessments were updated after the development of the SAPs. It was not evident that teaching strategies were revised when updated assessments were submitted after the annual ISP meeting. 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 IHCP. The facility had made progress in developing comprehensive ISPs that integrated all supports and services. However, as noted throughout section F, assessment information was often not available prior to the ISP meeting. Further, it was not evident that recommendations from assessments obtained after the annual ISP meeting were integrated into the ISP. When developing the ISP for an individual, the team should consider all recommendations from each discipline, along with the individual's preferences, and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. Observation at annual ISP meetings and pre-ISP meetings indicated IDTs were making considerable progress towards integrating protections, services, and supports into one comprehensive plan. In the past, each discipline would report independently on each particular assessment/plan related to their own discipline. IDTs now were holding a much more integrated discussion and most discipline representatives appeared comfortable discussing supports in each area. This was particularly evident at the two pre-ISP meetings observed. It is expected that progress will continue to be made in developing comprehensive plans as IDTs become more adept at developing both functional and measurable outcomes.	

#	Provision	Assessment of Status	Compliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Method for implementation As discussed in F2a2, some 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. Significant progress had been made in regards to incorporation of assessment recommendations by each discipline into training and support strategies included in the skill acquisition plans. As previously noted, each discipline will need to ensure that assessments are completed prior to the annual ISP meeting to ensure training strategies are developed using current recommendations from each discipline. IHCP action steps were generally brief statements of action to address the risk or references to additional plans (i.e., PNMT, PBSP). Most did not include methodology or criteria for monitoring effectiveness of intervention. Time frame for completion A sample of ISPs were reviewed to verify that outcomes included a time frame for completion. All (100%) included projected completion dates. In all cases, however, the date was an annual date rather than a date based on the individual's expected rate of learning or projected need for specific supports. Staff responsible All SAPs and IHCPs in the sample included designation of which staff /discipline 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.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The 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. 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 in key areas of their lives. For example, outcomes did not address	Noncompliance

#	Provision	Assessment of Status	Compliance
		increasing independence in routine household activities, such as laundry, yard work, and meal preparation. Few of the ISPs in the sample included adequate 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. Vocational outcomes were not found that would develop vocational skills needed for community employment. Vocational skills were general in nature and did not address barriers to working in the community. 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 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 type of data to be collected and the frequency of implementation were to be in 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. 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 F2d, however, designation of the person responsible for collecting and monitoring data did not ensure that data were consistently collected and monitored. For example, • Data sheets for Individual #345 for August 2013 showed that no data were recorded for one outcome and incorrect data were recorded for a second	Noncompliance

#	Provision	Assessment of Status	Compliance
		outcome. Data sheets for September 2013 showed that no data were collected for two of her three outcomes because the data collection sheets were missing. • For Individual #11, the QIDP noted in her monthly review that data were not available for three of her outcomes. • For Individual #74, the QIDP monthly review indicated that data were not available for review for two of his outcomes in August 2013. For September 2013, data were unavailable for one outcome and inaccurate for another outcome. • For Individual #101, the QIDP monthly reviews for July 2013, August 2013, and September 2013 indicated that implementation did not occur for her outcome to attend a music event on campus because "no concert was scheduled." Her outcome to attend a social event was not implemented in August 2013 or September 2013 because "no social events were available." IDTs will need to develop outcomes that are measurable in order to permit objective analysis of the individual's progress.	
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, behavioral health services, 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. When assessments were recommended by the team, it was not evident that the ISP was revised to include recommendations once the assessment was completed. 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
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in all (100%) of records reviewed. The facility reported the following data in regards to the requirement that ISPs were filed within 30 days of development. There had been a significant improvement in ensuring that plans were available to staff within 30 days of development. The QIDP Coordinator reported that the recent assignment of ISP facilitators to the IDTs had a positive impact on the timely submission of ISPs.	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>
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<tr><th>Month</th><th>Number of ISPs not filed within 30 days of development</th><th>Percentage of ISPs filed late</th></tr>
<tr><td>July 2013</td><td>25/37</td><td>68%</td></tr>
<tr><td>August 2013</td><td>13/22</td><td>59%</td></tr>
<tr><td>September 2013</td><td>4/28</td><td>14%</td></tr>
<tr><td>October 2013</td><td>1/39</td><td>3%</td></tr>
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DSPs interviewed during the review were much more familiar with healthcare supports and programming outcomes for individuals that they were assigned to support. It was noted that staff were not always consistently documenting plan implementation.

The facility needs to continue to ensure that all plans are accessible and comprehensible to staff assigned to implement the plan and staff can clearly communicate what supports should be provided and what data should be gathered.

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:
1. All outcomes should be written in clear, measurable terms.
2. ISPs should be accessible to staff within 30 days of the development of the plan.</td><td></td></tr>
<tr><td>F2d</td><td>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</td><td>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. QIDPs were responsible for reviewing the overall plan.

The facility had implemented a new QIDP monthly review process to review all supports and services. 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. QIDP comments regarding progress towards outcomes were generally a restatement of the outcome with no additional information to assess progress or determine appropriateness of the outcome. An adequate review process was not in place for any of the ISPs in the sample. For example,
• The QIDP monthly review of services for Individual #117 contained minimal detail on progress towards meeting outcomes in the ISP. Data reported by the</td><td>Noncompliance</td></tr>
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#	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.	QIDP did not match data from the DSP data collection sheets. For example, the QIDP reported that he had attempted his outcome to apply his walker breaks before transfer 16 times. The corresponding data sheet showed 26 successful attempts during the month. For October 2013, data sheets indicated successful attempts 29 times. The QIDP reported 27 times. When his ISP was developed in July 2013, the IDT rated him as medium risk for falls because he had seven falls documented over the previous year. Supports to address falls were included in his ISP. QIDP monthly reviews indicated that he had four additional falls in the quarter following development of his ISP. The team did not reconvene to address his falls, nor did the QIDP note any follow-up necessary to address his falls. The QIDP noted that the RN case manager recommended continuing all supports listed in his IHCP, though there was no evidence that all supports had been reviewed by the QIDP to confirm implementation. • The QIDP monthly review for Individual #74 indicated that he did not participate in his outcome to go out in the community weekly for the month of August 2013 because he was "not feeling well." Additionally, data indicated that he refused to attend work "most days" in August. The QIDP did not comment on follow-up to his not feeling well for the entire month of August. For September 2013, the QIDP monthly review indicated that he had "refused most activities due to not feeling well." Again, there was no documentation of a referral to the nurse or physician. He had many complex health issues and was rated as high risk for cardiac disease, dental disease, circulatory issues, fluid imbalance, and diabetes. • QIDP monthly reviews for Individual #368 listed the following incidents with no evidence of follow-up, changes in supports, or recommendations from 10/15/14 to12/22/13: o 10/15/13 Fell, reopened wound o 10/22/13 Physical aggression with injuries o 10/24/13 Attacked and bit by peer o 10/31/13 Bit by a peer o 11/21/13 Reopened an old wound o 12/7/13 Tripped and fell hitting his head on metal hand rail o 12/12/13 Reopened a wound on hand o 12/19/13 Bit by a peer on upper back o 12/22/13 Fell hitting hand on table As discussed in section D of this report, the facility needs to review trends of incidents and injuries and revise supports and protections when current supports are not effective for keeping individuals safe. Information regarding trends related to incidents and injuries was being provided to IDTs, however, it was not yet evident that IDTs were effectively using this information to develop or revise supports.	

#	Provision	Assessment of Status	Compliance
		As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QIDPs 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, 1. QIDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues or consider revising supports. 2. Plans should be updated and modified as individuals gain skills or experience regression in any area.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	In order to meet the Settlement Agreement requirements with regard to competency based training, QIDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document. The facility had recently been trained by the state office on developing and implementing the ISP. QIDPs were still learning to use the new statewide ISP format to develop the ISP. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at LSSLC. Staff instructions for many plans did not offer enough information to ensure consistent implementation or did not include recommended support strategies from assessments. Informal interviews throughout the facility indicated that staff were generally able to describe supports and services developed through the ISP process. A review of data collected regarding implementation indicated that data were often missing or the status of outcomes could not be determined. See comments regarding the monthly review process in F2d. To move forward, the facility will need to ensure that plans are available and training on new or revised supports occurs within 30 days of development.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within	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 all records reviewed. The monitoring team requested a list of ISP dates with the date the ISP was due, the date	Noncompliance

#	Provision	Assessment of Status	Compliance
	thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	the meeting was held, and the date the ISP was filed (document V.10). Data provided by the facility for October 2012 – October 2013 indicated that while all ISP meetings were held within 365 days of the previous ISP meeting, only 62% of the ISPs were filed within 30 days of development. The data indicated a significant improvement in timeliness of ISP submission for September 2013 and October 2013. As noted throughout this report, IDTs were not always revising support when individuals failed to meet outcomes or had a change in status that would require a review of supports.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility had expanded QA activities in regards to ISP development and implementation. According to the facility self- assessment, the following activities were completed to assess compliance with section F requirements: • Fourteen monitoring tools had been completed since July 2013 • Trends were analyzed and findings were being presented to the QAQI Council. • Active Treatment Coordinators were performing implementation audits • The QIDP Coordinator was reviewing the composition and quality of ISPs submitted. • The QIDP Coordinator Assistant was reviewing PSIs and training summaries. • Observations were conducted of staff implementation of outcomes. • The facility had a system in place to track the submission of assessments and attendance of staff at ISP meetings. The facility had just begun to analyze findings and develop corrective action plans based on self-assessment findings regarding the ISP process. Progress had been made towards developing an effective quality assurance system to identify problems with the ISP and implementation, though this process had not been in place long enough to determine the effectiveness of the process.	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 6/18/13 o LSSLC Facility Operational Procedures Manual Committee and Councils -12, Clinical Services Morning Meeting, 1/24/12, revised 6/1/13 o LSSLC Section G Self-assessment o LSSLC Section G Action Plan o LSSLC 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 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. A number of activities were listed in the self-assessment. The assessment for provision G1 consisted primarily of the review of various meeting minutes to determine if attendance was appropriate and

	discussions were integrated. For provision G2, data related to consult audits was reported as well as the results of the medical audits. The data related to consult audits was not reflective of the findings of the monitoring team. There was clear evidence that compliance was not 100%. Additionally, the facility continued to report data for a medical audit question that was not valid. For future self-assessments, the facility should have data generated by new tools created to measure integration. It will be important to determine if these tools are a valid and reliable means of measuring integration of clinical services. 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 substantial compliance with both provision items. The monitoring team found both provision items to be in noncompliance.
	Summary of Monitor's Assessment: The facility made some progress in this area. A process for assessing integration of services was developed. The assessment for one individual was completed the week prior to the compliance review and, unfortunately, it was reported that several clinical areas did not participate as required. There was improvement in the integration of neurology and psychiatry, but work was still needed in this area. The pretreatment sedation process showed improvement. The clinical disciplines were required to meet and discuss cases rather than simply circulate documents for signature. Medical participation in annual ISPs showed improvement from the two previous compliance reviews, but remained poor. 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 strengths and opportunities for improvement observed by the monitoring team are discussed in this report. Most providers were using an IPN template for documentation of consults, but the results of use varied. Consultations were being reviewed and documentation occurred. The content of the documentation did not meet the requirements outlined in local and state policy. In many instances, the entries did not provide any meaningful information about the consultation. Most consults indicated that referral to the IDT was not necessary. This occurred even when it was logical to refer the consult to the IDT for discussion of necessary supports. In the case of one provider, the documentation usually did not satisfy any of the requirements above the requirement to make an IPN entry. During the previous compliance review, problems related to consult tracking were reported. A new procedure was implemented to address this problem and facility staff indicated that consult tracking was no longer an issue.

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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. The facility had a local policy to help guide how integration would occur. The policy also addressed the minimum common elements of care covered in section H. The facility developed a process for measuring integration of clinical services. The *Quality Services Review of ISP and Integration of Services* tool was developed to assess the quality of services provided to the individuals and their families as defined within the domains of (1) Functional Skills Assessment, (2) Individual Team, (3) Individual Plan, (4) Habilitation, Training, Education, Skill Acquisition, and (4) Active Record. Tools were developed for services provided by medical, residential, pharmacy, dietary, dental, social workers, transition, vocational/day elements, behavioral health services, habilitation, human rights, nursing, psychiatry, and active treatment (QIDP). The goal was to have the disciplines complete the tools. Feedback was then provided to the disciplines and IDT of the person under review regarding the quality of the integrated services. The services for Individual #298 were reviewed one week prior to the compliance review. It was reported that all of the disciplines required to participate did not complete the tools as required. Feedback to the IDT had not occurred, but it would appear that this process would be most beneficial if all of the required disciplines participated. 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: • The facility continued its daily clinical services meeting. The lead physician, all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, habilitation staff, and psychologist attended this morning review. The events of the past 24 hours were discussed, including hospital admissions, consults, dental restraints, medical restraints, and off-campus appointments. Consults and other information was provided, however, the monitoring team observed that discussion about some of the data should have occurred, but did not. This forum provided an excellent opportunity for the clinical disciplines to discuss care issues that required integration. • Pretreatment Sedation Committee – A pretreatment sedation consultation procedure was implemented to require a collaborative approach between the	Noncompliance

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		clinical disciplines involved in the process. A meeting was conducted on Tuesdays and Thursdays to discuss the most appropriate medications, risks, and benefits. This was an improvement over the old process, which required no direct discussions. • When quarterly psychiatry clinics or other psychiatric clinical consultation occurs, there were members of the IDT present for integration including psychology, nursing, QIDP, direct support staff, and therapy services. • The PNMT worked well together for assessment and follow-up with IDT members. The PNMT RN consistently attended morning medical meetings and PNMT members routinely attended IDT meetings as needed. There were very clear referral guidelines in place to assist the IDTs in recognizing when referral was indicated. Once a referral was generated, the IDT participated routinely during PNMT and ISPA meetings to integrate recommendations into the ISP, IRRF, and IHCP. • Examples of integration were noted between speech and psychology related to the development of supports and interventions for individuals with severe communication deficits and behavioral concerns. • Behavioral health services demonstrated improvement in the functional integration with psychiatry, dental clinic, medical, and habilitation services. Several areas offered great opportunities for improvement: • Physician participation in the annual ISPs remained poor. For the reporting period, the PCPs attended 31 of 177 (17%) meetings. While this was an improvement from the 10% reported during the last compliance review, this was a low number. There were no data available for PCP participation in ISPAs. This was important because the PCPs should attend ISPAs that occur following hospitalization. • Suction toothbrushing – The provision of this treatment was essentially delegated to the medical department. PCPs identified individuals and wrote the orders for treatment. The home managers supervised the direct care professionals who actually provided the treatment. There was no oversight of this program by the dental department to ensure that treatment was properly done and effective. • The monitoring team attended one of the facility's Individual Support Plan meetings, which was held for Individual #551. The individual's direct support professional and relevant clinical services team members were present during the meeting. As the team discussed risk, the RN Case Manager provided current information regarding the functional decline that was associated with a change in seizure medications. During the discussion of health risks choking and aspiration, the RN Case Manager along with others did not have an	

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		understanding of the two risks in order to make a determination of risk. The Nursing Department should ensure that all RN Case Managers have been sufficiently trained in the identification of risk, risk factors, and the underlying pathophysiology of the risk. • Although some PCPs participated in the medication variance meeting attended by the monitoring team, committee meeting minutes documented a lack of medical participation since the previous compliance review. The facility was attempting to increase participation by direct care nurses, PCPs, and psychiatrists. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating of noncompliance. Several actions will be required for the facility to move towards substantial compliance: 1. 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. 2. The comments and recommendations discussed above should be addressed.	
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 Settlement Agreement required that medical providers review consultations 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. The facility implemented an operational procedure *Process for On-Campus/Off- Campus Consultations and Treatment Procedures* on 12/15/13. The procedure described the process for requesting consultations, the requirements for documentation of consult reports, and the tracking of consultations. It specifically required a summary of the consultation and treatment recommendations. It also required that providers document agreement or disagreement with recommendations and a decision regarding IDT referral. The consults and IPNs for the individuals included in the active record sample were reviewed. A total of 50 consults completed after June 2013 were reviewed: • 38 of 50 (76%) consultations met the documentation requirements to summarize the consult, agree or disagree, and comment on the need to refer to the IDT.	Noncompliance

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		The facility director reported that providers were using the standardized template for documentation of responses to consultations and 593 of 593 (100%) consults documented acceptance or rejection. It was also reported that 5 of 593 (.8%) documented any need to refer the consult to the IDT for integration with existing supports and services. It was not clear who completed the audits and how the results were obtained. Record reviews clearly documented that one provider did not use this template and did not provide the required documentation in the IPN. In fact, IPN entries were four lines, and usually provided a summary of less than 25 words. The IPN documentation for Individual #286 offered several examples of inadequate documentation. On 1/9/14, the SOAP note stated "see consult" for the objective findings. There was no documentation of agreement/disagreement or the need to refer to the IDT. On 12/18/13, the IPN entry again referred the reader to see consult. There was no agreement/disagreement or discussion of the need to refer to the IDT. One specific example of this deficiency was noted on 10/4/13: S – rev HTN O – Hallet (the name of specialist) A – HTN P – RTC 1 year with EKG/Echo labs before This style of documentation was consistently observed for one provider who was assigned to some of the most medically fragile individuals. The facility director should review the audit process to determine how such a marked deviation from the requirements failed to be reported by the auditor. Other providers utilized the template with varying degrees of success. Some providers signed the IPN entries, but clearly did not actually make the entries. For many, the information provided little relevant information to the IDT. For example, the documentation for the Hematology-Oncology consult for Individual #267 stated in the assessment that the individual was admitted to the hospital for pneumonia and respiratory insufficiency. The purpose of the entry was to document the results of the consult and not the general status of the individual. Clearly, a plan related to the consult hindered on the outcome of the hospitalization, but this IPN entry should have documented the assessment of the condition, in this case the consultant's explanation for the anemia, that was evaluated by the specialist. While the PCPs summarized the recommendations, this was not always done in a meaningful manner. In support of the self-rating of substantial compliance, the facility director also reported	

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		that the external audits completed in August 2013 showed 100% compliance with the questions associated with consultations referrals: • Question 44 – When a referral for consultation is requested, is pertinent current and past medical history included in communication with consultant? • Question 45 – Are medical and/or surgical consultations addressed in the IPN within five business days after the consultant recommendations are received? • Question 46 – If consultation recommendations are not implemented is there a clear explanation on the IPN as to why the provider has chosen to not implement the recommendations. The majority of consults found in the records included minimal or no historical information on the consult, but documented that appropriate information and documents were attached. However, these attachments would not be included in the active records. Therefore, the monitoring team cannot determine how the external reviewer concluded 100% compliance with this requirement. Moreover, there were consults in which the consultants clearly documented that information, such as drug levels, urinalysis and, seizure graphs, were not available. Record reviews also provided numerous examples of IPN entries that did not document agreement, disagreement, and the decision to refer to the IDT. With regards to the referral to the IDT, many consults should have been referred to the IDT, but were not. Individuals who required surgical procedures, such as cataract removal, should logically have the consult referred to the IDT, so that the appropriate supports prior to and following surgery could be implemented. Likewise, individuals undergoing painful dental procedures, such as whole mouth extractions off campus, required implementation of special supports. These consults should be referred to the IDT for discussion. As cited in previous reports, Question 45 does not adequately address the provision requirements because it fails to require the specific documentation related to agreement/disagreement and IDT referral. It is not helpful and it is misleading to continue to use this question in determining a self-rating. The provider who initiated the use of this format continued to provide to utilize the template and provide appropriate documentation. When properly executed, this format had the ability to meet the documentation requirements <u>Compliance Rating and Recommendations</u> The monitoring team disagreed with the facility's self-rating of substantial compliance. The appropriate documentation was not consistently completed by all providers with one provider clearly deviating from the required practice.	

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		To move in the direction of substantial compliance, the providers must review and document consults in accordance with state guidelines. The use of the IPN template can be an effective means of doing this if providers include all requirements and provide meaningful information related to the recommendations. The state medical services coordinator should address the validity of Question 45 of the medical audits.	

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 LSSLC Section H Self-assessment o LSSLC Section H Action Plan o LSSLC 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 self-assessment did not provide any data for several areas that were reported to have assessment tools. Future self- assessments should include data related to quality of assessments. This will require that audit tools have metrics that are specific and measurable. The facility found itself in noncompliance with provision H1 and H4. The monitoring team agreed with this self-assessment. Provision H2 remained in substantial compliance. The other provisions were not monitored as per the agreement between the parties and the Monitor.
	Summary of Monitor's Assessment: During the week of the onsite visit, the monitoring team had the opportunity to meet with the facility director, clinical services director, QA director, and QA nurse. The facility's QA nurse served as the lead for this provision item. At the time of the compliance review, the facility had addressed the timeliness of scheduled assessments. Several clinical disciplines had tools to evaluate the quality of assessments, but no data were provided to the monitoring team. Some disciplines were tracking quarterly assessments and evaluating quality, but no data were reported for those areas. There were no systems in place to track interval/unscheduled assessments by the clinical disciplines. The risk thresholds audit process provided information for the IDTs for their response to a change in status and development of new plans. 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 monitoring team also reviewed Provision H4. The facility presented data on the medical management audits for this section. Minimum common elements had been established for several conditions, but the additional steps required to use that information to determine efficacy of treatments had not occurred. The facility had 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.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an	The state office policy, which remained in draft, required each department to 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, there was 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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	individual's status to ensure the 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, The facility reported the following compliance data: Facility Assessments 2013 Jun / Jul / Aug / Sep / Oct / Nov Dental -- -- 97 85 95 100 Dietary -- -- 88 85 5 0 Hab: OT/OT -- -- 0 4 6 0 Hab: SLP/Comm. -- -- 67 67 20 Medical -- -- 53 62 54 68 Nursing -- -- 81 88 95 95 Pharmacy -- -- 56 42 5 0 Psychology -- -- 78 73 77 79 Psychiatry -- -- 82 94 83 83 Overall Rate -- -- 70 70 58 55 Beginning in November 2013, disciplines were required to have all annual assessments completed and uploaded to the appropriate drives 15 days prior to the ISP. Assessments received after the 10th day prior to the ISP were considered delinquent. The monitoring team inquired specifically about the 365-day requirement for medical and dental assessments. The facility director reported that she was not aware of a 365-day requirement for these assessments. Departments were required to have internal processes for tracking annual assessments. It was documented that the medical and psychology departments did not have tracking for several months due to staff vacancies. Psychiatry, nursing, dental, psychology, Habilitation PT/OT, and dietary were reported to have tools in place to evaluate the quality of annual assessments. The medical, Habilitation Comm/ST/Audiology had not developed tools. The pharmacy department had a tool to assess the quality of the QDRRs, but it was not utilized. The dental department completed quality assessments, but data were not compiled or utilized for performance improvement. Overall, the facility did not provide any data related to the quality of the discipline specific annual assessments. A new centralized tracking process was implemented in November 2013 for tracking	

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		quarterly assessments for medical, nursing, pharmacy, and psychiatry. The nursing, pharmacy, and psychiatry departments had internal systems to track quarterly assessments. The medical department did not track quarterly summaries. Compliance data for quarterly assessments were not presented or documented in the self-assessment. There were no systems in place to track interval/unscheduled assessments for the clinical disciplines. The risk thresholds audit process provided information on teams meeting and updating plans in response to change in status. However, this did not adequately address the need to evaluate discipline specific interval 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: • The compliance for timely completion of Annual Medical Assessments was 51%. This was a decrease in compliance since the previous review when 82% of assessments were noted to be timely. Medical assessments are discussed in detail in section L1. • Quarterly Medical Assessments were found in all records included in the record sample. The quality of the assessments is discussed in section L1. • The completion of Quarterly Drug Regimen Reviews declined since the last compliance review. Compliance for the reporting period was 45%. The facility had a corrective action plan in place to address this deficiency. • Annual Dental Assessments – Compliance with timely completion for the review period was 88%. The dental department reported 93% compliance. Additional details on dental assessments can be found in section Q1. • There was minimal improvement in the initial assessments and ongoing assessments in response to developments, changes, or monitoring and reporting of the individual's health conditions. For the majority of the records reviewed, nursing assessments were not performed consistently in response to changes in the current or ongoing health problems. • A listing of all individuals evaluated per Appendix B was requested. This list contained the names of 175 individuals. As there were a total of 181 individuals receiving treatment via the psychiatry clinic, the facility psychiatric practitioners had completed 97% of the evaluations on the individuals currently assigned to clinic. • Psychiatry clinic was generally timely with regard to completion of quarterly medication reviews. There were three individuals, 1.6% of the total population, participating in psychiatry clinic that were long overdue for quarterly clinic. • The PNMT conducted assessments for individuals referred to the team. These	

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		assessments resulted in a series of recommendations for the IDT and the PNMT to address collaboratively. Follow-up was also collaborative, as PNMT members attended IDT meetings when the individual they supported was scheduled for review. • OT/PT assessments were completed annually for individuals provided direct and indirect supports and services in the format of a Comprehensive Assessment or Assessment of Current Status. These were also completed when a change in status was identified by the IDT, post-hospitalization, or by referral for an identified need. The details of actions or consults by the PNMT were generally documented in the IPNs, though the quality of this was inconsistent. • As described in other sections of this report, the timeliness of OT/PT and communication assessments continued to be problematic, though improvement was noted in the last couple of months for OT/PT. There continued to be a significant lack of timely communication assessments. There had been limited improvements noted in the content aspect of the OT/PT and communication assessments. • The behavioral health services department had good compliance with requirements to complete assessments. Ninety eight percent of individuals had current psychological assessments, 94% had annual psychological assessments, and 100% of individuals with a PBSP had a functional assessment <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, 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	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, but updating of the documents improved since the previous review. • Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed examples of	Substantial compliance

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	Classification of Diseases and Related Health Problems.	documentation of specific criteria exhibited by an individual indicating a particular diagnosis. Compliance Rating and Recommendations This provision item remains in substantial 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 parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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.	In order to assess compliance with this provision item, the facility reported data on the medical management audits completed in August 2013 and November 2013. The August 2013 audits covered seizures and constipation. The November 2013 audits reviewed seizures, constipation, and UTI. The internal and external medical audits provided some assessment of efficacy of treatments. However, the audits needed to be expanded to include additional conditions. The results of the medical management audits and discussion of inter-rater reliability are discussed in section L2 and section L3. Guidelines were completed for common elements of care for eight conditions. At the time of the compliance review, the medical department had not completed training on these guidelines. The medical compliance coordinator discussed selection of clinical indicators and development of tools during interviews. It was reported that audit tools would be developed following the onsite review. Assessing compliance with a given protocol will require that a measurable standard or metric (i.e., clinical indicators) be developed. 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. Compliance Rating and Recommendations The monitoring team agreed with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the facility must develop clinical indicators and audit tools that reliably assess efficacy of treatment interventions.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review	Noncompliance

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	full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	stands.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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.	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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 facility's 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 contractures 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 with metabolic syndrome o List of individuals who were missing and/or absent without leave o List of individuals required to have one-to-one staffing levels o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o Data reports regarding the submission of assessments for IDT review prior to annual ISP 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 #418, Individual #410, and Individual #551 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #11 Individual #117, Individual #170, Individual #599, Individual #556, Individual #368, Individual #43, Individual #110, Individual #101, Individual #345, Individual #401, Individual #337, Individual #74, Individual #511, Individual #555, Individual #458, Individual #522, Individual #494, Individual #518, and Individual #410 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, psychologists, and QIDPs in homes and day programs; o Robin McKnight, Director of Behavioral Health Services o Luz Carver, QIDP Coordinator o Mike Ramsey, Incident Management Coordinator o Gail Husband, Assistant Director of Programs o Paula McHenry, Quality Assurance Director o Mary Bowers, Chief Nurse Executive o Danielle Perry, Habilitation Therapy Director <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 1/13/14 and 1/14/14 o ISP preparation meeting for Individual #326 and Individual #502 o Annual IDT Meeting for Individual #418, Individual #410, and Individual #551 o Castle Pine Unit Meeting 1/14/14 o 559 Home Team Meeting 1/16/14 o Executive Safety Committee Meeting 1/16/14
	Facility Self-Assessment: LSSLC submitted its self-assessment updated 12/30/13. 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 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. To assess compliance, the facility: • Reviewed a sample of 15 IRRFs developed between August 2013 and November 2013; • Reviewed a sample of 11 action plans for individuals rated at medium or high risk;

	• Reviewed the assessment database to determine if assessments were completed prior to the annual ISP meeting and posted to the share drive for review by IDT members; and • Reviewed a sample of 51 ISP addenda for individuals that had a change of status to determine if appropriate assessments were completed to address the change of status. Findings from that review were similar to findings by the monitoring team. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed.
	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. The facility had recently completed intensive training with a consultant on implementing the ISP development process. QIDPs and nursing staff had been retrained on developing the IHCPs. The facility continued to train DSPs on identified risks for individuals and how to implement supports to address those risks. The parties agreed that the monitoring team would conduct reduced monitoring for I2 and I3 because the facility had made little progress. The facility was not in compliance with the three provisions in section I. The monitoring team observed the risk identification process at three ISP meetings and noted some, but overall, very little progress made. IDTs were still not engaging in integrated discussion regarding risk levels and supports were not being monitored and revised as needed to address risks identified. It was still evident that some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decisions regarding appropriate interventions. Without adequate assessments completed prior to the meeting, it was difficult to make clinical determinations in regards to risks. Teams were not consistently documenting the completion of assessments and resulting recommendations. 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. As noted throughout this report the monitoring team has many concerns related to the accurate identification of risk factors for individuals and the processes that the facility has in place to address those risks. To move forward with section I: • The facility needs to continue to focus on ensuring that all relevant team members are present for meetings and that assessments are completed prior to the discussion of risks. • 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. • Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should

	meet immediately and action plans should be revised.

#	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 (IHCP) 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. IHCPs were designed to provide a comprehensive plan to be completed annually and updated as needed. The monitoring team observed three IDT meetings. Progress towards developing an effective process to identify risks was observed in both meetings. IDTs were utilizing the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). At the IDT meetings observed, each discipline presented relevant information during the risk determination process, however, integrated discussion that could have led assigning accurate risk ratings was limited during the meetings. In most cases, the IDTs agreed to continue supports that were already in place to address risks, even when data indicated that the supports had not been effective. 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. The facility had begun to track submission of assessments by discipline. The submission of assessments was a barrier to accurately identifying risks and support needs for individuals. Data submitted by the facility indicated that all disciplines were not routinely completing IRRF assessments prior to annual ISP meetings. The table below shows the percentage of assessments submitted 10 days prior to the risk discussion by discipline for July 2013 through October 2013.	Noncompliance

Discipline	July	August	September	October
Medical	30%	50%	62%	51%
Psychiatric	100%	82%	94%	83%
Nursing	88%	81%	88%	95%
Dental	100%	97%	85%	95%
QDDR	12%	56%	42%	5%
Psychology	76%	78%	73%	77%
OT/PT	6%	0%	4%	3%
Communication	100%	0%	67%	67%
Audiology	89%	92%	100%	94%
Nutrition	36%	88%	85%	5%

#	Provision	Assessment of Status	Compliance
		A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. The sample included Individual #345, Individual #11, Individual #43, Individual #117, Individual #458, and Individual #599. Zero (0%) of six individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. Without current assessment data available, IDTs cannot accurately assess risks. It will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP. Though there had been some improvements in using assessment results to assign risk ratings, it was not yet evident that all individuals had accurate risk ratings determined by assessment results. For example, • Individual #117's IRRF indicated that he was at medium risk for choking and falls. His PNMP rated him as high risk in both categories. His IRRF indicated that he was at low risk for aspiration while his PNMP indicated that he was at medium risk for aspiration. His IRRF listed constipation as a low risk area, though his annual physical exam list chronic constipation as a current problem. His annual physical indicated that he was below his ideal weight range and on a high calorie diet. His nursing assessment indicated that his weight was stable. His nutritional evaluation indicated that he was on a regular diet to maintain his weight, though was above his ideal weight range. The IDT rated him as low risk for weight issues. • Individual #74 was rated low risk for skin integrity. His annual medical exam noted that he had been seen in the wound clinic numerous times over the previous year. His active problem list included stasis dermatitis of both lower legs with chronic leg ulcers, xerosis of skin, generalized psoriasis, and diabetes. His nursing assessment indicated that he was at high risk for skin infections. His psychological assessment stated that he had engaged in harmful self-injurious behaviors, mainly scratching skin on his arms and legs. His OT/PT assessment recommended a high risk rating for skin problems due to lower extremity edema, psoriasis, dermatitis, and xerosis, as well as, self-injurious behaviors. In order to mitigate risk prior to a significant event or change in status, IDTs should carefully consider all risk indicators and conservatively assign risk ratings with the intent of implementing supports to minimize risks before an adverse outcome or change in status occurs.	

#	Provision	Assessment of Status	Compliance
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. 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. As noted in section F, data were often not consistently reviewed. This raised the question of whether or not IDTs were using data to identify when individuals might have a change of status that would require a change in supports to mitigate risk factors. At the ISP meeting for Individual #551, the IDT reviewed her IRRF following the discussion regarding her preferences, programming, and living options. Her health risks had a major impact on how she spent her day. The team should have integrated the risk discussion in planning for the upcoming year. At one point, her behavioral health specialist raised the issue that her lethargy was impacting training opportunities and how she spent her day. The team agreed that planning for her was difficult because she was only awake for an hour or two a day. The facilitator stated that they would talk more about her lethargy in the risk discussion. This would have been an excellent opportunity to talk about her risks and healthcare needs in relation to how she spends her day. The nurse led the risk discussion for Individual #551 by reading assessment information entered into the IRRF prior to the meeting. There was minimal input and discussion from other team members. The nurse was not open to discussion when other disciplines attempted to raise questions or add information regarding each specific risk. The individual had many complex unresolved health issues. In most cases, the team agreed to continue supports already in place without reviewing the supports in place. In some cases, it was not evident that supports in place were effective. For example, she had been rated as a medium risk for gastrointestinal issues the previous year. The team agreed that current supports were adequate and she should remain at medium risk. Data presented by the nurse showed that she had nine episodes of vomiting over the past year (a decrease from 11 the previous year). Clinical data relating to the episodes were not available and not discussed by the IDT members. After being prompted by the monitoring team, the IDT agreed to change the risk rating to high, but did not consider additional assessments or a revision to supports in place. The team did not have specific data related to her lethargy and did not engage in a thorough discussion regarding healthcare issues that were impacting her ability to participate in meaningful programming. Many of these issues should have been discussed at her pre-ISP so that assessment information could be presented during the risk discussion. It was a concern	Noncompliance

#	Provision	Assessment of Status	Compliance
		that the IDT was aware that her healthcare issues were effecting her day prior to her annual ISP meeting, but did not recommend further assessments or review her supports in an attempt to address the issues prior to her annual meeting. At the annual ISP for Individual #418, the risk discussion was also conducted following discussion regarding his preferences, programming, and living options. Each discipline read assessment information entered into the IRRF prior to the meeting. There was minimal discussion regarding his risk ratings and supports. The team agreed to continue most supports without reviewing action steps and assigning specific staff to review and monitor supports. The monitoring team also attending the annual ISP meeting for Individual #410. Again, the team spent a lot of time reviewing assessment information that was entered into the draft IRRF, but little time discussing integrated factors that might contribute to the risk category. The team relied heavily on historical data rather considering factors that might impact his health in the future. For example, the IDT agreed to a low risk rating for diabetes because lab work did not show that he was diabetic. Consideration was not given to his risk for developing diabetes in the future related to his weight or use of Zyprexa to address behavioral issues. Additionally, the team did not have current data related to all supports in place to determine the effectiveness of all interventions. The IDT had recommended a weighted vest and blanket to address his behavior. Data were not available to assess the effectiveness of this support. Having an adequate system in place to follow-up on all assessments and review data is an essential part of the risk identification process. 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 following a change of status. 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 QIDP monthly review process did not document implementation of action steps included in the IHCP. Thus, it was not possible to determine if assessments were completed or if recommendations from assessments were incorporated into supports and tracked for efficacy. The monitoring team reviewed a sample of assessments from various disciplines to determine whether or not an adequate assessment process was in place to address	

#	Provision	Assessment of Status	Compliance
		identified risk. Findings by discipline are summarized below. <u>Nursing</u> Based on a review of 12 records, eight had completed nursing assessments, IRRFs, and IHCPS. Five of eight (63%) included sufficient nursing assessments to assist the team in developing appropriate plans sufficient to meet the individuals health care needs. <u>Medical</u> See section L and N regarding the identification of medical risk factors. <u>Behavioral Health Services</u> Based on a review of 13 functional assessments, 100% were judged to adequately address individual's behavioral risk. <u>OT/PT</u> OT/PT assessments were often not completed 10 days prior to the ISP. The assessment tracking log submitted indicated that for ISPs dated 7/1/13 through 2/27/13, only 50% of the assessments were performed on, or prior to, the designated due date. It was noted, however, that since 11/29/13 (for ISPs since 12/13/13), 100% were listed as completed on time	
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 parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. 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 risks for all individuals designated as high 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 always possible to determine if IDTs implemented all recommendations from assessments within 14 days. For the QIDP monthly reviews,	Noncompliance

#	Provision	Assessment of Status	Compliance
		the QIDPs were not documenting implementation of action steps or reviewing status of IHCP outcomes. For example, • Individual #368 was at high risk for falls. At his annual IDT meeting on 4/15/13, his PT assessment indicated that he had 28 falls the previous year. Supports were put into place to address his risk for falls, though supports had not been effective at decreasing his risk. As evident by ISPAs in his record, the IDT had met numerous times to address falls following his annual IDT meeting. Several new assessments were recommended by the IDT including consultation with the PNMT, an ophthalmologist, and a mobility specialist. His IHCP had not been updated since May 2013. It was not possible to determine if all recommendations from those assessments had been implemented and monitored for effectiveness. The team was not consistently tracking status of those interventions. He continued to experience a high number of falls (19 additional falls from 11/1/13 to 1/15/14) indicating that supports were not effective. His QIDP monthly reviews did not note monitoring of outcomes to address his risks. • Individual #511's IDT had met numerous times over the past year to review injuries, functional regression, changes in sleep patterns, and changes to his medications and PNMP. It appeared that the team had recommended and obtained several new assessments over the past six months. According to documents provided to the monitoring team, his IRRF and IHCP had not been updated since his annual ISP meeting on 6/27/13. It was difficult to determine if all assessments had been obtained and if recommendations from those assessments were implemented and then monitored for efficacy. 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., monitor weights weekly, 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: 1. Develop action plans with measurable criteria for assessing outcomes.	

#	Provision	Assessment of Status	Compliance
		2. Document the implementation of action plans. 3. Document that clinical data is gathered and reviewed at least monthly. 4. 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 Two examples of medical desensitization support plans, one dental simulation support plan, and two skill acquisition plans. 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 PBSP 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 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 PBSP 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 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 Ten examples of comprehensive psychiatric evaluations per Appendix B performed in the previous six months. o Documentation of psychiatry attendance at ISP, ISPA,PBSP, 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 six instances of 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. Vyas' clinic on 1/15/14 regarding Individual #123, and Individual #279. o All information presented, doctor's notes and documentation regarding Dr. Buckingham's clinic 1/14/14 regarding Individual #354. o All information presented, doctor's notes and documentation regarding Dr. Middlebrook's clinic 1/13/14 regarding Individual #212, Individual #370, and Individual #380. o Documentation from ISP meeting 1/13/14 regarding Individual #410. o Documentation from pretreatment sedation meeting 1/14/14 regarding Individual #524. o For last three months tracking information regarding polypharmacy follow-up. o All information presented, doctor's orders and documentation from neurology clinic 1/15/14 regarding Individual #127, Individual #310, Individual #321, Individual #542, Individual #532, Individual #66, and Individual #301. o Ten examples of the neurology/psychiatry consultation report. o Total number of ISP meetings vs. number of ISP meetings psychiatry attended for the previous six months. o Correction to the initial document request regarding consultation for pretreatment sedation to include the back page of the consultation document. o DADS policy regarding psychiatric services o All handouts from the opening meeting. o Tracking spreadsheet regarding psychiatry/neurology consultation. o Four examples of psychiatry peer review (one for each provider). o 10 examples of psychiatry IIRF submissions. o Tracking spreadsheet regarding timeliness of IIRF submission. o Five examples of MOSES and DISCUS assessments printed from AVATAR o Process for psychiatry review of PBSP as outlined in policy o All information presented, doctor's orders and documentation from Doug Douglas, P.A. clinic 1/16/14 regarding Individual #97 and Individual #591. 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 #555, Individual #301, Individual #221, Individual #318, Individual #368, Individual #97, Individual #249, Individual #410, Individual #22, Individual #220, Individual #505, Individual #392, and Individual #175. <u>Individual Interviews and Meetings Held</u>: o Dr. Jafri, facility dental director o Judd Williamson, R.N., Psychiatric Nurse o James Buckingham, M.D., lead psychiatrist with Judd Williamson, R.N., Psychiatric Nurse o Luz Carver, Director of QIDP services o Robin McKnight, MA, LPC, BCBA, Director of Behavioral Health Services o Tom Middlebrook, M.D., facility psychiatrist with Judd Williamson, R.N. Psychiatric Nurse o Mary Bowers, R.N., Chief Nursing Executive o Jodella Winn, psychiatry administrative assistant, Judd Williamson, R.N., and Caleb Nelson, LVN o Janet Way, Pharm.D., clinical pharmacist o Andra Self, clinical services director o Judd Williamson, R.N., with Doug Douglas, P.A., and Shyam Vyas, M.D. o Brian Carlin, M.D. with Tammy Nelson, LVN <u>Observations Conducted</u>: o Dr. Middlebrook's clinic on 1/13/14 o Dr. Vyas' clinic 1/15/14. o Doug Douglas, P.A. clinic 1/16/14. o Dr. Buckingham's clinic 1/14/14. o Neurology clinic 1/15/14. o ISP dated 1/13/14. o Behavior Therapy Committee

	o Polypharmacy Committee Meeting o Pharmacy and Therapeutics Committee o Clinical Services Meeting o Pretreatment sedation meeting o QA/QI 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 eight provision items: J1, J2, J6, J7, J8, J12, J13, and J14. The monitoring team agreed with all eight of these J1, J2, J6, J7, J8, J12, J13 and J14. Additionally, J10 was found in substantial compliance based on documentation of the risk/benefit analysis for the treatment with psychotropic medications. When reviewing psychiatric documentation in total, this information was included.
	Summary of Monitor's Assessment: Psychiatry services at LSSLC made progress towards substantial compliance. The facility was found to be in substantial compliance with nine of the 15 items in this provision of the Settlement Agreement. Over half of the individuals residing at the facility received psychopharmacologic intervention (181 of 338, 53%). 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 .79 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. The current psychiatric providers were experiencing difficulty with the level of documentation required. It was discussed with the psychiatric clinic staff during this monitoring visit that they could consider electronic documentation completed during psychiatry clinic in an effort to reduce the redundancy in the current documentation. There were some challenges noted during this monitoring visit, as overall, there had been a reduction in the percentage of ISP meetings that psychiatry had attended. Although the total number of meetings

	attended had remained relatively constant, there were more meetings scheduled. Given the paucity of psychiatric resources at this facility, attendance at additional meetings was not possible. It was noted that psychiatry clinic staff were doing an excellent job scheduling and utilizing current resources to their full capacity. Psychiatry sustained 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, QIDP, direct care staff, and the individual). A review of psychiatric documentation revealed improvements with the justification of diagnoses and identification of nonpharmacological interventions. Collaboration with neurology had improved, in that there were consultation documents presented to neurology outlining the psychiatrist's queries for neurology, and during this monitoring visit, the IDT inclusive of psychiatry was present in clinic for two individuals. Psychiatry clinic staff indicated plans for their administrative staff to assume the responsibility for neurology clinic scheduling and coordination, which may improve the ability for psychiatry to participate in consultations. There were improvements reported in the psychiatric participation in the development of the PBSP. This was occurring during psychiatry clinic, however, documentation of this process was not uniform, and the psychiatrist's signature was not located on the PBSP document. There were several areas where the facility was able to achieve or maintain substantial compliance ratings (e.g., J1, J2, J6, J7, J8, J10, J12, J13 and J14). In some areas, psychiatry was approaching substantial compliance, however, it was the functions that were dependent upon other departments (e.g., primary care, pharmacy) 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.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The parties agreed the monitoring Team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	<u>Number of Individuals Evaluated</u> The psychiatrists had continued to perform comprehensive psychiatric assessments per Appendix B. At the time of this visit, 97% of individuals participating in psychiatry clinic had completed comprehensive psychiatric assessments. <u>Evaluation and Diagnosis Procedures</u> 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, sustained 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 continued to systematically review 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 and updated for the psychiatrist to utilize when dictating and/or documenting, resulting in improvements in both the quality and consistency of documentation among psychiatric providers. <u>Clinical Justification</u> 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 were noted. A review of 13 records of individuals at LSSLC revealed appropriate documentation in the quarterly medication reviews. Psychiatry clinic had also continued the peer review process. 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." Four examples of peer review documentation, one for each provider, were requested for review. Only one was received. This review included pertinent comments and was signed and acknowledged by the provider being reviewed. Given the above, it was apparent that the facility psychiatric staff continued attempts 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 sustained 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 181 individuals participating in psychiatry clinic, the majority of individuals were seen quarterly. Where quarterly psychiatric clinic reviews were outdated, 29	Substantial Compliance

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		individuals were last seen in August 2013, 4 individuals were last seen in July 2013, one individual was last seen in June 2013, one individual was last seen in May 2013, and one individual was last seen in March 2013. As such, there were three individuals who were far overdue for psychiatry clinic follow-up. Individual #516 was last seen in March 2013. This individual was prescribed Risperdal and Valproic Acid. <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. There were three individuals who were far overdue for psychiatry clinic, and it will be necessary for these individuals to be scheduled and reviewed as soon as possible. Given sustained improvements, this provision is in substantial compliance, in agreement with the facility self-assessment.	
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 13 records, all had diagnoses noted in the record. Individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In 13 of the 13 records reviewed, there was a PBSP on file. Of the 13 records reviewed, none 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 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	Noncompliance

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		was 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 examples included in the discussion for J9). 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 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. <u>Emergency use of Psychotropic Medications</u> The facility use of emergency psychotropic medication for individuals during periods of agitation/aggression had decreased. During the previous monitoring period, there were 14 incidents. For this monitoring period, there were seven incidents. These seven incidents were attributed to three individuals, with Individual #410 receiving emergency psychotropic medication on five of the seven. Given the presentation of the data, it was not possible to determine if the treating psychiatrist or primary care physician ordered the chemical restraint, however, per the facility self-assessment, it was noted that for six events reviewed, none were ordered by the psychiatrist or coordinated with the psychiatrist. Per the facility self-assessment, documentation regarding six instances of chemical restraints was reviewed. Of these, five of six included documentation indicating a graduated range of less restrictive measures had been attempted. All examples included documentation indicating that the individual posed an immediate threat or serious risk of harm to self or others. And three of six examples included restraint review and debriefing	

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		documents that were completed within 10 days as required by policy. This was consistent with the monitoring team's review of the documentation. <u>Monitoring Team's Compliance Rating</u> 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 lack of signed PBSP documents. Improvements had been noted, specifically the psychiatric review and documentation of nonpharmacological interventions. The facility self-assessment did not review the psychiatrist's participation in the development of the PBSP and the documentation thereof. With regard to chemical restraints, there had been an decrease in instances, with the majority of these instances attributable to one individual. 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 agreement with 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. 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	<u>Extent of Pretreatment Sedation</u> The facility reported a total of 97 instances of pretreatment sedation between 6/3/13 and 11/18/13. This was a reduction from the previous monitoring period where there were 156 instances. Given the presentation of the data, however, it was not possible to determine if these sedation episodes were for dental or medical treatment. In 18 of these instances, Versed, Ketamine, or a combination of these two medications were utilized, and this was assumed to indicate TIVA. Interestingly, of the total of 97 instances of pretreatment sedation, 61 (or 62%) were for individuals participating in psychiatry clinic who were prescribed psychotropic medications. <u>Interdisciplinary Coordination</u> During the month of September 2012, the facility instituted a pretreatment sedation consultation process. This system was included in policy and procedure entitled "Client	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.	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 despite efforts at desensitization and behavioral modification, then authorization for treatment must be obtained. The facility had drafted policy and procedure dated 11/22/13 entitled "Pre-Sedation Consultation Procedure" that outlined the process for the completion of the consultation and review of planned pretreatment sedation. 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 on Tuesdays and Thursdays following the morning clinical meeting. During this monitoring visit, there was one consultation reviewed. Of the 10 examples available for review, six did not include the second page where the consensus recommendations are documented. It should be noted that these documents were requested again during the monitoring visit with specific instructions to include the second page of the document. Of the remaining documents, all were complete in that they included documentation of the consensus meeting. The primary care provider signed all examples, but there was no documentation included with regard to his or her opinion of the proposed treatment. Psychiatry signed all 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 as 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, the need for communication regarding the utilization of pretreatment sedation must continue. <u>Monitoring After Pretreatment Sedation</u> A review of documentation for nine individuals regarding 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 plan to systematically address medical and dental desensitization. As part of this, 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. 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 support professionals, despite training, were not knowledgeable with regard to toothbrushing. As such, facility hygienists had continued their focus on training direct support professionals 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. In the intervening period since the last monitoring visit, the dental staff had continued outreach into the individual's homes with regard to encouraging oral hygiene. In addition, dental appointments were being scheduled in outlook so that psychology staff were aware of a scheduled appointment and could attend in order to assist with the process. Interviews with psychology staff revealed that, in collaboration with dental clinic and other members of the IDT, strategies to assist individuals with regard to accepting dental treatment or other interventions were being included in the individual's Integrated Health Care Plans. This process was relatively new, and there were plans to train the IDT on this process. Given this emerging process, there was less focus on formal desensitization plans, and a greater focus on strategies to assist individuals. This was appropriate. The list of individuals with medical and dental desensitization plans or skills acquisition plans was reviewed. Per this document, nine individuals had plans in place. Three individuals had dental desensitization plans, three individuals had medical desensitization plans, and four individuals were either utilizing or scheduled to utilize the dental simulator. For additional information regarding the quality of these plans, please see section K.	

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		Monitoring Team's Compliance Rating In agreement with the facility self-assessment, this item will remain in noncompliance because continuing effort must be made with respect to interdisciplinary coordination for those individuals requiring pretreatment sedation. As noted above, the facility had made great efforts with regard to developing a process to review individuals who required pretreatment sedation. They had also progressed in the assessment of individuals in 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.	Psychiatry Staffing Approximately 53% of the census (181 individuals) received psychopharmacologic intervention requiring psychiatric services at LSSLC as of 1/13/14. There were three part-time psychiatrists and one physician's assistant totaling, per the facility self-assessment, .79 FTE. Current scheduling allowed for psychiatry presence on campus Monday through Friday. It was reported that the psychiatrists and physician's assistant were also 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. Administrative Support Psychiatry clinic staff included a psychiatric nurse, a psychiatric licensed vocational nurse (LVN), and a psychiatric administrative assistant. The psychiatry clinic team remained organized and enthusiastic, and had benefitted from both the designation of the lead psychiatrist and their interaction/relationship with the lead psychiatrist. This team was noted to consist of self-motivated individuals who will require direction to focus their efforts toward goal accomplishment necessary to satisfy the requirements of the section J provisions. It was noted that over the course of the period since the previous monitoring visit that, with the addition of the LVN, the psychiatry clinic staff continued to make great strides Determination of Required FTEs The current allotment of psychiatric clinical services was not sufficient to provide clinical services at the facility. At the time of the review, there were a total of 31 available clinical hours weekly.	Noncompliance

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		LSSLC rated this item in noncompliance and documented their review of the current psychiatric resources in the self-assessment, indicating that the psychiatrists had been able to perform timely annual and quarterly psychiatric reviews, attend ISP meetings (attending 47 of 77 annual ISP meetings since July 2013), attend required committee meetings, and participate in the development of the PBSP. The self-assessment also indicated that psychiatrists were able to collaborate with neurology, however, although this had improved somewhat, remained an area of deficiency. See the discussion under J15. 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 130 psychiatric clinical resource hours per month, with a caseload of 181 individuals, there were enough hours for each individual to have approximately 40 minutes 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. The facility was attempting to recruit; ongoing efforts will be necessary. One issue noted in staff interviews remained the level of documentation required by the psychiatrists. In an effort to address this and reduce paperwork allowing for increased time for clinical services and interaction with the IDT, the utilization of a projector/screen and typing clinical documentation during the clinic process may be helpful. The QIDP, 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.	

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		Monitoring Team's Compliance Rating Due to the lack of sufficient psychiatric resources to provide the services required, this provision remained in noncompliance. This was in agreement with the facility self-assessment.	
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. Per the facility self-assessment, the facility had added prompts to the form in order to improve documentation. These prompts included, "Psychiatric Diagnosis…target symptom monitoring…derivation of psychiatric symptoms…statements which reflect collaboration between psychiatry and psychology…pharmacological intervention…risk/benefit discussion." Evaluations Completed A listing of all individuals evaluated per Appendix B was requested. This list contained the names of 175 individuals. As there were a total of 181 individuals receiving treatment via the psychiatry clinic, the facility psychiatric practitioners had completed 97% of the evaluations on the individuals currently assigned to clinic. Per the facility self-assessment, 10 Comprehensive Psychiatric Assessments were reviewed. Of these, 100% addressed symptoms supporting a psychiatric diagnosis, 100% included target symptom monitoring, 100% included derivations of psychiatric symptoms, 80% reflected collaboration between psychiatry and psychology, 100% included pharmacological interventions, and 60% included documentation of the risk/benefit analysis. Review of Completed Evaluations A review of nine completed comprehensive evaluations revealed that these evaluations were completed between 9/16/13 and 11/13/13. (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	Substantial Compliance

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		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. <u>Monitoring Team's Compliance Rating</u> Review of documentation revealed sustained 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 remains in substantial compliance in agreement with the facility self-assessment.	
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	<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 eight individuals admitted to the facility since 6/12/13. Of these, all received Reiss Screening following admission. Of these, seven individuals were referred for a comprehensive psychiatric evaluation. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> The total facility census was 338, with 181 individuals enrolled in psychiatry clinic. Therefore, 157 individuals were eligible for baseline Reiss screening. Information received for this visit revealed that all individuals not currently participating in psychiatry clinic had received a baseline Reiss Screening. In addition, data revealed that regardless of psychiatric participation, the vast majority of individuals had received the Reiss Screen regardless of their psychiatric clinic status. Data revealed of a total of 338 individuals, 46 individuals had "N/A" with regard to Reiss Screening. Of these, all were participating in psychiatry clinic. <u>Reiss Screen for Change in Status</u> Data provided from psychiatry clinic revealed that four individuals had received the Reiss	Substantial Compliance

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	justifiable manner.	Screen due to a change in status in the period between 7/1/13 and 1/13/14. In all cases, 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 10.7 days between referral and assessment (range 0-21). <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> Per an interview with psychiatry clinic staff and a review of facility based policy and procedure regarding psychiatric services, the "Psychiatry Services Procedure Manual" dated 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 outlined timelines within which psychiatry would review an individual with a positive Reiss Screen. <u>Monitoring Team's Compliance Rating</u> The facility 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 data presented above by the monitoring team was echoed in the facility self-assessment. Given the improvements in data presentation and utilization of the Reiss Screen as noted above, this provision is in substantial compliance in agreement with the facility self-assessment.	
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, QIDP, DSP, dietary, habilitation therapy, and workshop representatives outlining a system to integrate pharmacological treatment with behavioral and other interventions.	Substantial Compliance

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		Interdisciplinary Collaborative Efforts Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinic, the collaboration between the disciplines had continued 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 9 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. Integration of Treatment Efforts 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 potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies). As data presentation was improved, the next step is for psychology to analyze the data and present hypotheses for improved clinical utility. Data collection practices are also discussed in section K. Collaborative Diagnostic Formulations A review of the comprehensive psychiatric evaluations of nine individuals revealed that all contained a case formulation. In eight 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 consistent from the previous review. • Individual #363: Per the comprehensive psychiatric evaluation dated 11/13/13, documented as completed in collaboration with the IDT, each psychiatric diagnosis	

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		was reviewed and particular symptomatology that the individual exhibited indicating criteria for the disorder was discussed. Per the case formulation, treatment modalities were reviewed, as were factors that could result in decompensation, risks of medication, risks of illness, polypharmacy justification, and non-pharmacologic interventions were documented. Per the facility self-assessment, 10 Comprehensive Psychiatric Assessments were reviewed. Of these, data indicated 100% included a case formulation, 70% contained collaborative language, 100% identified symptoms for monitoring, and 100% included tracking data regarding symptoms/behaviors. <u>Monitoring Team's Compliance Rating</u> There was continued attention to 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 the continued practice, this provision will be rated in substantial compliance in agreement with the facility self-assessment.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving 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,	<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. Per the facility self-assessment, a review of a sample of 10 of 77 records for individuals prescribed psychotropic medications who had an ISP during this monitoring period revealed that 100% of the PBSP documents included interventions addressing the signs and symptoms of the diagnosed illness, 100% of the comprehensive psychiatric assessments addressed non-pharmacological interventions, 100% of the ISP documents addressed non-pharmacological interventions, and 80% of the PBSP sampled included the psychiatrist's signature on the document indicating review and input into the plan. A review of 13 records by the monitoring team, however, revealed no examples of the psychiatrist's signature on the PBSP document. A review of the psychiatric documentation revealed inconsistent references to participation in the development of the PBSP. It was noted that documentation of this process was provider specific. 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	Noncompliance

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	interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	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 PBSP meetings was reviewed. Between 6/3/13 and 12/13/13, there were a total of 110 ISP meetings with documentation indicating that psychiatry was present at 71 meetings (65%). It should be noted that in the previous monitoring report, the psychiatrist's attended 92% of meetings. For this monitoring period, while there were a greater number of total meetings, the psychiatrists attended approximately the same total number of meetings (i.e., 71 meetings this period versus 72 meetings in the previous period). Admittedly, psychiatric attendance at ISP meetings is challenging given the schedules of the providers, while there is a provider on campus daily, the providers rotate and have different clinic days. There were no notations of psychiatric attendance at PBSP meetings. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> Per a review of the PBSP documentation provided in the records of 13 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 <u>all</u> meetings regarding the PBSP, there must be <u>some</u> participation/collaboration and documentation of this participation/collaboration in the process in order to satisfy the requirements of this provision item. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> Non-pharmacological interventions were discussed during 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.	

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		There were ongoing improvements noted in the breadth of non-pharmacological interventions identified for individuals during the annual psychiatric evaluation process. For example: • Individual #299 - "the family has outlined with [individual] a series of goals which will give tremendous guidance to the IDT in assisting…in the direction of being able to leave this facility at some point in the future…goals of his being able to hold a job, making friends, taking his own medication, participating in his own self care and hygiene, being able to manage money and shop for himself in a responsible way…habilitative therapy needs to complete an evaluation…likely that he is going to need some sort of auditory interventions to decrease his hypersensitivity. Life skills classes…given the task of writing down his thoughts and feelings, and this may be helpful to him." • Individual #40 - "begin special education services…in a combination of self contained classes and in the regular classroom…committee will meet...for this transition…assessment by the workshop to determine an appropriate level of work…basketball and perhaps other sports in active therapy…art through school and on the campus…music therapy and the home CD playing…cooking lessons…to help him with his diabetic diet. He has shown a great interest in cooking and in eating." There were other examples where improvements were needed. For example: • Individual #55 - "enrolled in the local high school…assessed for needs for workshop and other medical needs will be assessed…including need for speech and occupational therapy." 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 were also noted to have increased collaboration with regard to the development of non-pharmacological interventions. <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 this process was not evident in the document review, this provision was rated in noncompliance in agreement with the facility self-assessment.	

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		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 IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	<u>Policy and Procedure</u> A review of DADS policy and procedure entitled "Psychiatry Services," dated 5/1/13 noted that state center responsibilities included that the psychiatrist, in collaboration with IDT members, must "determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications." Facility-specific policy "Psychiatry Services Procedure Manual," dated 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." As discussed in J14 below, DADS developed a statewide policy regarding informed consent. Completion of this policy was pending at the time of this monitoring visit. Once this policy is implemented, facility policy will need to be revised as necessary to reflect the statewide requirements. <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	Substantial Compliance

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		been expanded since the previous monitoring visit. A prompt had been added to the comprehensive psychiatric assessment in order to improve physician compliance with this documentation requirement. Per the facility self-assessment, 10 of a total of 90 records (11%) were reviewed to determine if the content of documentation included a risk/benefit analysis. Data indicated that, of the records reviewed for psychiatric documentation, 70% contained risks regarding a specific medication, 50% included information regarding the risks of the mental illness, and 50% included documentation of the risk/benefit discussion. Additional data revealed that, of these 10 records, 0% included documentation of the risk/benefit discussion in the ISP, 50% of psychiatric assessments included documentation of the risk/benefit discussion, and 0% of consent forms addressed the risk/benefit discussion (risks and benefits were listed, but no analysis was documented). A review of the records of 18 individuals at the facility who were prescribed various psychotropic medications (13 requested records onsite 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 always highlighted in a specific section of the documentation, the information was included when documentation was considered in toto. For example: • Individual #199 - the annual psychiatric assessment dated 10/22/13 reviewed the behavioral challenges that this individual historically displayed. The document also reviewed specific psychiatric symptomatology. The document reviewed current psychotropic medications and the efficacy of these medications, "the fact that her mood is typically more stable and she ahs fewer outbursts with greater lengths of time between, suggested this medication is helpful in treating her illness…although…there are obvious spikes periodically." The document extensively reviewed this individual's medical history, laboratory examinations, and MOSES/DISCUS scores. Risks, including medication side effects and decompensation were reviewed, culminating in the opinion of the team that "she is best served through a combination of behavioral and pharmacological interventions." In addition, nonpharmacological interventions outside of the PBSP were documented and individualized. 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.	

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		• Given the comprehensive manner in which psychiatry clinic was conducted during the review, the elements necessary for this documentation appeared to be readily available. As discussed with facility staff during the monitoring review, the success of this process of developing an organized response to an individual's psychotropic medication regimen inclusive of risk/benefit analysis, informed consent, and justification of a medication regimen will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. As stated in J13 below, as representatives from various disciplines are present in psychiatry clinic, the inclusion of the IDT process during psychiatry clinic could be an avenue for ensuring the IDT process is followed with respect to the requirements of this provision. <u>Observation of Psychiatric Clinic</u> During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed the medication regimen with the team members present in clinic. The development of the risk/benefit analysis should be undertaken during psychiatry clinic. The team should consider reviewing this type of information together via a projector/screen and typing the information <u>during</u> the clinic process. The QIDP, 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. <u>Human Rights Committee Activities</u> A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). <u>Monitoring Team's Compliance Rating</u> As noted above, the facility was in the process of developing a consistent process for the formulation, documentation, and review of the risk versus benefit analysis for treatment with psychotropic medication as well as the identification of alternate non-pharmacological interventions. Although the facility self-assessment provided data indicating	

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		noncompliance, review of the documentation in totality revealed that the information was generally present, just not under a specific heading. During the monitoring visit, the burden of documentation was discussed several times. The psychiatric physicians were frustrated with the amount of duplicate documentation and, as such, the recommendation for the development of the shell document and completion of this document during psychiatry clinic is most salient. The facility self-assessment provided a noncompliance rating for this provision, however, review of the documentation provided revealed that when reviewing the documentation in total, the requisite information was included, therefore, this provision is in substantial compliance. For future self-assessments, review of the documentation in total is recommended in the data collection process for this provision.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	<u>Facility-Level Polypharmacy Review</u> The facility had their initial monthly polypharmacy review committee 11/1/12. Per the document request, the facility held one polypharmacy committee meeting during the current monitoring period, however, per the facility self-assessment, there were two meetings (October 2013 and November 2013). Following the hiring of a clinical pharmacist, the responsibility for polypharmacy data collection and presentation had been shifted to the pharmacy. During this monitoring visit, a polypharmacy meeting was observed. Per staff interviews, monthly polypharmacy meetings were planned. <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 43 individuals. These justifications were collated from the documents referenced above. In addition, in preparation for "Psychoactive Polypharmacy Committee Review," the prescribing psychiatrist completed a form documenting justification for the medication regimen. One issue discussed with facility staff during the monitoring visit was the omission of medications utilized to address seizures. These medications were not prescribed by psychiatry, however, did impact the polypharmacy data and medication regimens with regard to side effects and interactions. It will be necessary for facility providers and the polypharmacy committee to ensure that these medications are included and reviewed. It is understood that the inclusion of these medications may initially skew polypharmacy data, however, this is necessary for a comprehensive review of regimens.	Noncompliance

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		It was discussed at length during the previous visit and, given the issues noted above, reiterated, that polypharmacy, per se, is not always inappropriate 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. The justifications reviewed during the polypharmacy meeting observed were more complete that in previous reviews. In addition, the facility level review, while thorough, was not without challenges. Because the psychiatrists and physician's assistant worked various schedules, the provider was not present in the review to observe the discussion or provide additional information or insight into the rationale for the regimen. This was performed by the lead psychiatrist. While the lead psychiatrist did an admirable job, it is challenging to discuss and defend the prescribing practices of another provider. It would be best if the prescriber were present. This will require scheduling changes (e.g., a revolving meeting held a different day every month with a particular provider being highlighted during the meeting he can attend), but this may not be feasible. As discussed above, there were marked improvements in documentation as compared to previous monitoring reviews. For example: • Individual #506 - documentation included a detailed review of this individual's target symptoms, antecedents to behavioral challenges (e.g., invading his personal space, asking him to do something he does not want to do), and activities that he participates in (e.g., workshop, weekly visits with his mother). The document then went on to describe each medication, the target symptoms and psychopharmacological rationale, including a review of the particular receptors targeted via each medication, and potential side effects. The document also included the physician's plans for future regimen adjustments. In contrast to previous monitoring reviews, it was noted that the majority of the six polypharmacy justifications reviewed during the polypharmacy meeting observed for this monitoring visit included information as described in the example above. <u>Review of Polypharmacy Data</u> Documentation presented during the polypharmacy oversight committee meeting 1/14/14 was reviewed. There were basic data presented, compared only to the previous month. As pharmacy had just assumed responsibility for the facility level review, longer term trending or tracking of polypharmacy data was premature. Per the data presented, an average of 27% of the individuals participating in psychiatry clinic met criteria for polypharmacy. The data revealed a total of 14 individuals meeting	

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		criteria for intraclass polypharmacy. There were 29 individuals prescribed three psychotropic medications and 15 individuals prescribed four psychotropic medications. Data from December 2013 indicated one individual prescribed five psychotropic medications, however, as of the January 2014 meeting, there were no individuals prescribed five or more medications. Again, with regard to these data, it is important to note that in the case of individuals prescribed seizure medications where additional benefit may be obtained from a psychopharmacological perspective, seizure medications were not included, and this must be addressed. <u>Monitoring Team's Compliance Rating</u> Psychiatry clinic staff had done a laudable job of authoring polypharmacy justifications, and initiating the facility level polypharmacy meetings in the absence of a clinical pharmacist. The responsibility for this process was transferred to the pharmacy. Given the ongoing challenges noted above, this provision was rated in noncompliance, which was the same as the 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. The facility could consider a rotating meeting in order to allow for participation of the psychiatrist under review. 2. Ensure monthly polypharmacy reviews. 3. 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. 4. Ensure that seizure medications are taken into account with regard to the polypharmacy data and regimen review.	
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	The parties agreed the monitoring Team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	least quarterly.		
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 5/1/13, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." 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 13 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 #249, the quarterly psychiatric assessment treatment plan dated 10/30/13 reviewed, in depth, this individual's target behaviors and symptoms, medication regimen, laboratory examinations, MOSES and DISCUS scores, diagnoses, biopsychosocial formulation, justification for polypharmacy, and nonpharmacological interventions. Other required elements (the expected timeline for the therapeutic effects of the medication to occur, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur) were located in the documentation regarding consent for new psychotropic medications. <u>Psychiatric Participation in ISP Meetings</u> At the time of the onsite review, there was stability with regard to the total number of ISP meetings that psychiatry had attended, but a marked increase in the total number of meetings held, which reduced the overall percentage of participation on the part of psychiatry staff. As noted in J9 above, between 6/3/13 and 12/13/13 there were a total of 110 ISP meetings with documentation indicating that psychiatry was present at 71 meetings (65%). It should be noted that in the previous monitoring report, the psychiatrist's attended 92% of meetings, however, for this monitoring period, while there were a greater number of total meetings, the psychiatrists attended approximately the same total number of meetings (e.g., 71 meetings this period versus 72 meetings in the previous period). Admittedly,	Noncompliance

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		psychiatric attendance at ISP meetings is challenging given the schedules of the providers, while there is a provider on campus daily, the provider's rotate and have different clinic days. There were no notations of psychiatric attendance at PBSP meetings 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. All treatment team disciplines were represented during the clinical encounter. The team did not rush clinic, spending an appropriate amount of time (often 35-45 minutes) discussing the individual's treatment. During clinic, the psychiatrists reviewed behavioral data. In general, the data were graphed, and up to date. There were improvements in the data graphs as some included timelines for medication dosage changes or stressful life events. In addition, now that data presentation was improved, psychology staff had begun to analyze the data presented including an interpretation of the data. This will 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, please see the discussion in J2 for additional information. Given the total number of individuals participating in psychiatry clinic (n=181), only 1.6% of the clinic population was	

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		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. Given the improvements, this provision is in substantial compliance in agreement with the facility self-assessment.	
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 5/1/13, "before prescribing psychotropic medications…the state center must provide information about the psychotropic medications to the individuals, their families, and/or their legally authorized representatives…must address characteristics of the medication, including expected benefits, potential adverse or side effects, dosage, and standard alternative treatments; legal rights; and any questions the individual, the family, and/or LAR have." In addition, DADS was in the process of developing a statewide policy regarding informed consent. This policy was pending at the time of this monitoring visit. 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." Following dissemination of the DADS statewide policy, facility specific policy may need to be updated in order to confirm to new statewide requirements. 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. The "Consent/Authorization for Treatment with Psychotropic Medication" form included requirements for information regarding the selected medication, diagnoses, dosage, dosage range, allergies, target	Substantial Compliance

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		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 or annual consent was not routinely noted in the records reviewed. <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 13 records revealed all records included documentation regarding annual medication consent, however, in two examples, the documents were not signed (Individual #175 and Individual #301). 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 ISPA addendum document regarding review of the proposed medication, with seven of these including documentation of psychiatric attendance at the IDT. One weakness noted in previous monitoring reports was the documentation of alternatives to medication treatment and the rationale for not implementing these at the time 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." During this monitoring review, there had been some reoccurrence of issues in this area. For example: • Individual #494 - "Any SSRI could be used, but Paxil is FDA approved for anxiety disorders." This describes the rationale for the choice of a particular agent. It does not include alternatives or non-pharmacological interventions. • Individual #298 - "Trazodone currently less effective than hoped." This gives a	

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		rationale for a trial of another medication. 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. Per the facility self-assessment, a review of a sample of 10 new medication consents revealed 100% compliance with regard to the areas reviewed: listed pertinent side effects, expected benefits of the drug' target symptoms, were verbally obtained by the psychiatrists, contained an expected timeline, and when involving a cross tapering, gave an explanation of the cross taper. These data points did not include documentation of alternatives to medication treatment and the rationale for not implementing these at the time. It is suggested that this is included in the data review for the facility self-assessment. <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. It may be necessary for the facility to revise policy and procedure to conform with pending DADS policy regarding informed consent. A facility review of the quality of the documentation was performed via the facility self-assessment. For future self-assessments, it is recommended that the facility include documentation of alternatives to medication treatment and the rationale for not implementing these at the time of the prescription in the review. In addition, it is also recommended that the facility include a review of annual medication consents. Given the ongoing consent procedures and quality review performed by the facility, this provision will remain in substantial compliance in agreement with the facility self-assessment.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure	<u>Policy and Procedure</u> Per DADS policy, Psychiatry Services dated 5/1/13, "when medications are prescribed to treat both seizures and a mental health disorder, the neurologist and psychiatrist must coordinate the use of medications through the IDT process." Facility policy and procedure	Noncompliance

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	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.	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 68 individuals participating in psychiatry clinic who had a diagnosis of seizure disorder. This was a decrease over the previous monitoring period where it was reported that there were 75 individuals participating in psychiatry clinic who had a diagnosis of seizure disorder. Per the facility self-assessment, nine individuals were seen in neurology clinic at the request of psychiatry. The time for completion of the consultation was an average of 15 days. At the time the self-assessment was completed, three consults were pending. Of the remaining six examples, four were found to contain evidence of collaborative language. <u>Adequacy of Current Neurology Resources</u> Per staff interviews and documentation reviewed, neurology consultation was available at the facility twice a month. Neurology clinic reportedly lasted approximately three hours, and during this period approximately 12 - 15 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 LVN was coordinating neurology clinic. Per staff interviews, it was planned for psychiatry to continue to schedule and coordinate neurology clinic. During the neurology clinic observed for this monitoring visit, two patient encounters were performed in consultation with psychiatry. • Individual #532 was experiencing behavioral challenges, however, a decrease in seizure activity. Following consultation between neurology, psychiatry, nursing case management, and direct support staff, it was determined that this individual's medication regimen would be maintained. • Individual #66 was also seen in consultation with neurology, psychiatry, nursing case manager, psychology, and direct support staff. Increased behavioral	

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		challenges were reviewed as well as environmental effects that may have precipitated these behaviors. The team had a good discussion regarding this individual's psychotropic medication regimen and the contribution of this individual's underlying medical issues to the behavioral challenges noted. The team was noted to collaborate with regard to the plan for further testing (CT of the brain, EEG), medication options, and plans to track data with regard to this individual's experience of headaches and their contribution to behavioral challenges. 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 68 individuals, 14 had not had neurology follow-up in the past year. This was an improvement over 22 individuals requiring annual follow-up identified in the previous monitoring period. Of these, 12 were last seen in 2012. One individual was last seen in 2009, another was last seen in 2001, and a second individual was last seen in 2005. Given these data, the need for increased neurological clinical consultation was apparent because 20% of the individuals treated in psychiatry clinic with a concomitant seizure disorder diagnosis had no documented evaluation by neurology in the previous 12 months. Given the above, it would be beneficial to determine the amount of clinical neurology resources needed via an examination of the number of individuals in need of neurology consultation and the recommended follow-up frequency. The facility should continue the pursuit of options for increasing neurologic consultation availability, specifically increasing the contract with the current provider, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities. <u>Monitoring Team's Compliance Rating</u> While there were gains noted with regard to policy and procedure outlining the process for psychiatry/neurology consultation, improvements in the documentation of collaboration, and evidence of collaboration occurring during neurology clinic, ongoing improvement in these areas is necessary. Specifically, increased evidence of interdisciplinary consultation. As such, this provision will remain in noncompliance in agreement with 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 (e.g.,	

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		annually). 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:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #357 (8/26/13), Individual #344 (6/20/13), Individual #466 (7/5/13), Individual #93 (8/3/13), Individual #112 (8/7/13), Individual #383 (8/16/13), Individual #387 (6/21/13), Individual #492 (8/13/13), Individual #245 (10/23/13), Individual #333 (8/16/13), Individual #368 (8/1/13), Individual #430 (10/17/13), Individual #203 (8/5/13) o Positive Behavior Support Plans for: • Individual #357 (8/26/13), Individual #344 (6/20/13), Individual #466 (7/5/13), Individual #93 (8/3/13), Individual #112 (8/7/13), Individual #383 (8/16/13), Individual #387 (6/21/13), Individual #492 (8/13/13), Individual #245 (10/23/13), Individual #333 (8/16/13), Individual #368 (8/1/13), Individual #430 (10/17/13), Individual #203 (8/5/13) o Six months of notes on PBSPs progress for: • Individual #357, Individual #344, Individual #93, Individual #112, Individual #387, Individual #492, Individual #245, Individual #466, Individual #383, Individual #368, Individual #430, Individual #203 o Full Psychological Assessments for: • Individual #261 (11/19/13), Individual #344 (6/20/13), Individual #547 (10/29/13), Individual #28 (6/26/13), Individual #318 (12/18/13), Individual #587 (8/9/13), Individual #110 (10/21/13), Individual #497 (12/1/13), Individual #592 (8/15/13), Individual #11 (10/24/13) o Annual Psychological updates for: • Individual #357 (8/26/13), Individual #466 (7/5/13), Individual #93 (8/3/13), Individual #112 (8/7/13), Individual #383 (8/16/13), Individual #387 (6/21/13), Individual #492 (8/13/13), Individual #245 (10/23/13), Individual #333 (8/16/13), Individual #368 (8/1/13), Individual #430 (10/17/13), Individual #203 (8/5/13) o Counseling Assessment and Treatment Plans for: • Individual #279, Individual #130, Individual #110 o Counseling Progress notes for: • Individual #130 o Behavioral Health Services Department: Peer Review/ Behavior Support Committee, 11/12/13 o Counseling Assessment and Treatment Planning Procedures, 11/21/13 o Section K self-assessment, 12/30/13 o Section K action plans, 12/28/13 o Peer review/behavior support committee reviewer form, 12/18/13

	o Data collection reliability spot checks form, undated o Psychology data collection, undated o List of the date of each individual's annual psychological assessment, undated o List of all individuals with PBSPs, including date of last plan revision/review, undated o Spreadsheet of individuals most recent psychological assessment, undated o Behavioral Health Services department meeting minutes for the past six months o A list of all individuals receiving counseling, undated o List of all behavioral health services staff and status of enrollment in BCBA coursework, undated o Section K presentation book, undated o List of individuals with a crisis intervention plan, undated o Section K Compliance Update, 1/14/14 <u>Interviews and Meetings Held</u>: o Robin McKnight, BCBA, Director of Behavioral Health Services o Robin McKnight, BCBA, Director of Behavioral Health Services; Mike Fowler, BCBA, Behavior Analyst; Kari Staley, BCBA, Behavioral Analyst; Kenneth Elerson, Behavioral Health Specialist V; Julie Bradbury, Behavioral Health Specialist o Kari Staley, BCBA, Behavior Analyst; Julie Bradbury, Behavioral Health Specialist III; Jill Harris, Behavioral Health Specialist III; Kathy Jennings, Behavioral Health Specialist III; Carol Bradley, Behavioral Health Specialist III; Stevie Hight, Behavioral Health Specialist III; Adam Williams, Behavior Analyst; Jule O'Donnell Garside, Behavioral Health Specialist III; Traci Swain, Behavioral Health Specialist, III o Keith Baily, Residential Services Manager; Mary Stovall, Oak Hill Unit Director; Kenneth Self, Woodland Crossing Unit Director; Rotley Tankersley, Castle Pines Unit Director; Todd Miller, Lone Pines Unit Director <u>Observations Conducted</u>: o ISP meeting for: • Individual #410 o Pre ISP meeting for: • Individual #326 o Psychiatric Review Meeting • Individual presented: Individual #354 o Psychiatric Review Meeting • Individuals presented: Individual #123, Individual #279 o Restraint Reduction Meeting o Peer Review Meeting • Individual presented: Individual #192 o Treatment Integrity collection • Staff observed: Linda Nouwen o Pre Treatment Sedation meeting

	o PBSP Staff Trainings • For Individual #298 o QAQI Council meeting 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: The self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared to be 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 behavioral health services 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 behavioral health services 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, K4, K5, K6, K7, K8, K9, K10, and K11. The monitoring team's review of this provision, as detailed in this report, found that the items rated in substantial compliance in the last review (i.e., K2, K3, K5, K6, K7, and K11) to be the only items in substantial compliance. The reasons for this discrepancy for K4, K8, K9, and K10 are discussed below. Finally, the self-assessment established long-term goals for compliance with each item of this provision. Because many of these items require considerable change to occur throughout the facility, and because it will likely take some time for LSSLC to make these changes, the monitoring team continues to recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that LSSLC 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 did not achieve substantial compliance for any additional items since the last review. The facility, however, maintained substantial compliance on the six items (K2, K3, K5, K6, K7, and K11) that were in substantial compliance prior to this review, and demonstrated improvements in several additional items. These improvements since the last review include: • 100% of staff that write PBSPs had either completed or were enrolled in coursework toward board certification in behavior analysis (K1) • Increase in the flexibility of the data collection system (K4) • Continued development of behavioral systems to ensure that PBSP data are recorded in a timely

	fashion, are reliable, and PBSPs are implemented as written (K4, K10) • Evidence of data-based treatment decisions (K4) • Development of a referral system to ensure that all individuals that need psychological services, other than PBSPs, receive them (K8) • Establishment of a tracking system to monitor the time from HRC approval to implementation of PBSPs (K9) • Expansion of the collection of treatment integrity data (K10) The areas that the monitoring team suggests that LSSLC work on for the next onsite review are: • Continue to expand the flexibility of the data system (K4) • Demonstrate that established minimum frequencies and levels of data collection reliability, IOA, and treatment integrity are achieved (K4, K10) • Ensure that all treatment sites are using the same methodology to collect and calculate data collection reliability, IOA, and treatment integrity (K4, K10) • 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) • Ensure that counseling services consistently contain documentation of progress on treatment goals (K8) • Document that PBSPs are consistently implemented within 14 days of receiving consent (K9) • 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 reasonable safety, security, and	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all of the staff at LSSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as board certified behavior analysts (BCBAs). At the time of the onsite review, three (23%) of the 13 staff that wrote PBSPs were BCBAs. Additionally, the director of behavioral health services, and the consulting behavior analyst were BCBAs. This is the same number of BCBAs reported in the last review. All 13 staff that wrote PBSPs (100%) were either enrolled, or completed coursework, toward attaining a BCBA. This represented an increase from the last review when 93% of the staff that wrote PBSPs were either enrolled in, or completed, BCBA coursework. The facility should ensure that all staff that write PBSPs have BCBAs. LSSLC provided supervision of behavioral health specialists enrolled in the BCBA program by contracting with a consulting BCBA from the community. LSSLC and DADS	Noncompliance

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	freedom from undue use of restraint.	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 behavioral health specialist's BCBA training and credentials.	
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 parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including 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.	LSSLC's self-assessment indicated that this provision item was in substantial compliance. Although improving, it was rated as being in noncompliance due to the issues discussed in detail below. At the time of the onsite review, LSSLC utilized multiple data systems. These included the recording of replacement and target behaviors in one- or two-hour intervals, and the circling of a yes or no in two-hour intervals or for an entire shift. Since the last review, there were examples of increased flexibility in the data system. For example, several individuals in home 523 had data collection sheets with individualized time intervals to better reflect the times their target behaviors were most likely to occur. Although these examples of flexibility in the data system are encouraging, each residential unit continued to use a different data system that was identical for the majority of individuals in that unit. It is recommended that LSSLC continue to increase the flexibility of its data system based on individual need rather than residence. In each of these data systems, direct support professionals (DSPs) 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 DSPs were recording data at the intervals specified (i.e., data collection reliability).	Noncompliance

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		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 7 of 12 data sheets reviewed (58%) were completed up to the two previous hours. This result was similar to the last review when 56% of the data sheets were recorded up to two previous hours. 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. LSSLC had established that every PBSP would have data collection reliability and IOA measures at least quarterly. Additionally, they established their goal level of data collection reliability and IOA to be 80%. Although the self-assessment indicated that data collection reliability and IOA were occurring in all four residential units at LSSLC, the facility could not document the frequency (i.e., how often they occurred) and level (i.e., the percentage scored) for each individual with a PBSP. The director of behavioral health services indicated that the facility was in the process of developing a tracking system that would allow them to document if they achieved their data collection frequency and level goals for future reviews. The monitoring team observed the collection of data collection reliability and IOA. The method used appeared to be reasonable, however, conversations with behavioral health specialists suggested that different residential units defined these behavioral systems differently. Over the next six months, it is recommended that LSSLC ensure that all treatment sites are using the same methodology to collect and calculate data collection reliability and IOA. Additionally, it is recommended that the facility demonstrate that data collection reliability and IOA are collected for each PBSP at least quarterly, and ensure that the average level is at least 80%. 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. The routine use of data to make treatment decisions also improved from the last review. In past reviews, current data were not consistently present at interdisciplinary meetings. During the present review, however, all three individuals discussed in psychiatry clinics had current data (the graphed data were two weeks old, but the behavioral health specialist in each case had the last two weeks of raw data) contributing to data based decisions concerning the use of medications or interventions. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for the 13 individuals, seven (Individual #344,	

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		Individual #112, Individual #387, Individual #245, Individual #333, Individual #368, and Individual #430), or 54%, indicated no obvious improvement in severe behavior. This represented a decrease from the last review when 33% of the individual's reviewed showed no obvious improvement in severe behavior. As discussed in the last review, the monitoring team found examples of action taken to address the lack of progress (e.g., Individual #368), however, the majority of progress notes reviewed (e.g., Individual #430, Individual #112) with a lack of treatment progress, documented no action to address the undesired outcome (e.g., retraining of staff, modification of PBSP, etc.). It is recommended that in those instances when an individual is not making expected progress, that the progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred. The monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility. The monitoring team acknowledges the efforts by LSSLC to improve the data system, and ensure that PBSP data are recorded in a timely fashion and are reliable. Over the next six months it is recommended that the facility expand the flexibility of the data collection system. Additionally, the facility needs to review the data collection reliability and IOA collection procedures to ensure they are consistent across the facility, and that established goal frequencies and levels are achieved. Finally, it is recommended that LSSLC 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.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	The facility continued to be in substantial compliance with this item. <u>Psychological Assessments</u> A spreadsheet of full psychological assessments indicated that 330 of the 338 (98%) individuals at LSSLC had a full psychological assessment. This is comparable to the last review when 97% of individuals had a full psychological assessment. The spreadsheet indicated that 46 full psychological assessments were completed in the last six months, and 10 of those (22%) were reviewed to evaluate their comprehensiveness. As found in the last three 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. <u>Functional Assessments</u> A spreadsheet provided to the monitoring team indicated that 200 of the 200 individuals with PBSP (see K9) had a functional assessment. One hundred and ninety one of those	Substantial Compliance

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		functional assessments (95%) were current (i.e., revised/reviewed within one year). This was consistent with the last review when 97% of the functional assessments were current. The spreadsheet indicated that 90 functional assessments were completed in the last six months. Thirteen of these (14%) 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. Additionally, all 13 of the functional assessments reviewed (100%) were judged to contain adequate direct assessment procedures. This represented an improvement from the last review when 88% of direct observation procedures were judged to be acceptable. 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 13 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, 13 of the 13 functional assessments reviewed (100%) were evaluated to be comprehensive and clear. This represents an improvement from the last review when 88% of the functional assessments reviewed were evaluated as acceptable. 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 are 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.	This provision item continued to be rated in substantial compliance. A spreadsheet of the dates of all psychological assessments (including intellectual and adaptive assessments) at LSSLC indicated that 327 of the 338 (97%) full assessments (see K5) were completed in the last five years. This represented another improvement from the last review when 90% of full assessments were completed in the last five years. 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 completed/revised in the last five years.	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 continued to be rated in substantial compliance. 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, and 94% were current. This represents a slight decrease from the last review when 100% of annual updates were current. A spreadsheet indicated that 197 annual psychological assessments were completed in the last six months, and 12 (6%) of these were reviewed by monitoring team to assess their comprehensiveness. All 12 annual psychological assessments reviewed (100%) 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.. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that all four 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 a psychological assessment completed with 30 days of admission.	Substantial Compliance
K8	By six weeks of the assessment required in Section K.7, above,	LSSLC's self-assessment indicated that they believed that this provision item was in substantial compliance. Although there were improvements, described below, the	Noncompliance

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	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.	monitoring team did not believe this item was in substantial compliance because the treatment plans for psychological services other than PBSPs did not consistently include documentation and review of progress. At the time of this onsite review, three individuals participated in counseling and/or psychotherapy. This represented a decrease from the last review when five individuals received psychological services other than PBSPs. Since the last review LSSLC initiated a formal referral process allowing treatment teams to recommend individuals for services. Treatment plans for all three of these individuals (100%) were reviewed to determine progress with this provision item. The treatment plans reviewed included the following: • Goals and measurable objectives • Qualified staff (i.e., psychologists with a degree in counseling) providing the services • A "fail criteria" that will trigger a review and revision of interventions to ensure that services do not continue if objective are not achieved • A plan to generalize skills learned to other settings Only one of the three treatment plans reviewed (33%), however, had a review of progress. It is recommended that LSSLC ensure that each treatment plan have progress comments that reflect the changes in the measurable objectives of the plan. In order to achieve substantial compliance with this provision, the facility will need to demonstrate that all psychological services other than PBSPs contain the following: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting	The facility's self-assessment indicated that this item was in substantial compliance, however, 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 200 individuals at LSSLC had PBSPs and 191 of these (95%) were current (i.e., reviewed/revised at least every 12 months). This	Noncompliance

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	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.	was comparable to the last review when 98% of PBSPs were current. All PBSPs had the necessary consent and approvals. Since the last review, LSSLC began tracking the time from receiving consent to the implementation of the PBSP. At the time of the onsite review, however, the tracking was not complete and documented that only 49 of 200 PBSPs (25%) were implemented within 14 days of receiving consent. LSSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. Ninety PBSPs were completed since the last review, and 13 (14%) of these were reviewed to evaluate compliance with this provision item. All PBSPs reviewed included descriptions of target behaviors, however, two (Individual #466 and individual #344) of these included a definition that was not operational (15%). This represented a decrease from the last review when all PBSPs reviewed contained operationally defined target behaviors. The reason these target behaviors were not rated as operational is: • Individual #466's PBSP defined disruptive behavior as "…*intentionally* sitting on the ground in order *to garner attention*…" • Individual #344's PBSP defined putting inedibles in her mouth as "Putting inedible substances into her mouth *for stimulation.*" These definitions required the reader to infer if individuals' behavior was to obtain attention, or if they engaged in the target behavior for stimulation. An operational definition should not require DSPs to infer an individual's knowledge or intentions. An operational definition should only include observable behavior. All PBSPs should include operational definitions of target behaviors. All 13 (100%) of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the hypothesized function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This was the same as 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. Replacement behaviors were found to be functional (when possible) for 13 of the 13 PBSPs reviewed (100%). This is consistent with the last report, when 100% of all replacement behaviors that could be functional were functional.	

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		When the replacement behavior requires the acquisition of a new behavior, 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 does not need to be written in the skill acquisition plan (SAP) format. Overall, 11 (Individual #357, Individual #93, Individual #112, Individual #383, Individual #387, Individual #492, Individual #245, Individual #333, Individual #368, Individual #430, and Individual #203) of the 13 PBSPs reviewed (85%) 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 is a decrease from the last review when 100% of the PBSPs reviewed were judged to be acceptable. In order to achieve substantial compliance with this provision item, the facility needs to document that PBSPs are consistently implemented within 14 days of receiving consent, and ensure that at least 85% of the PBSPs reviewed are complete.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The facility's self-assessment indicated that this item was in substantial compliance, however, it was rated as in noncompliance because the facility did not demonstrate that established minimum frequencies and levels of IOA and treatment integrity were achieved. At the time of the onsite review, IOA of target and replacement behaviors were collected for each individual with a PBSP. The facility established that IOA would be collected once a quarter for every individual with a PBSP and the level would be at or above 80%. As discussed in K4, however, LSSLC did not have a facility-wide tracking system to document that these frequencies and levels of IOA were achieved. All of the DSPs 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. Since the last review, LSSLC expanded the collection of treatment integrity from of the PBSPs to all four residential units. Additionally, the facility established that treatment integrity would be collected quarterly for every individual with a PBSP, and the minimal acceptable level would be 80%. The self-assessment indicated that a sample of integrity checks averaged 99%. Ten of the 13 PBSPs reviewed (77%) included treatment integrity data. As discussed for data collection reliability and IOA, however, there was not documentation that the established frequency and level of treatment integrity was achieved.	Noncompliance

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		Finally, the monitoring team observed the collection of treatment integrity, and found the treatment integrity tool and procedures to be appropriate for assessing treatment integrity. It appeared, however, that different treatment sites defined treatment integrity differently. During the next six months, it is recommended that LSSLC ensure that all treatment sites use the same methodology to collect and calculate treatment integrity. Additionally, it is recommended that the facility demonstrate that treatment integrity and IOA are collected for each PBSP at least quarterly, and ensure that the average level is at least 80%. Target and replacement behaviors were consistently graphed. All of the graphs reviewed contained horizontal and vertical axes and labels, condition change lines/indicators, data points, and a data path.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DSPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item continued to be rated as being in substantial compliance. LSSLC utilized a brief behavior support plan that was located in the individual books, and was written so that DSPs could understand them. The monitoring team reviewed 13 PBSPs written in the last six months and concluded that they were written in a manner that DSPs were likely to understand. The PBSPs reviewed were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 1.8 target behaviors per PBSP reviewed), 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 the PBSPs reviewed by the monitors and determined that they averaged a 9.7. Finally, the monitoring team also asked several DSPs across all treatment sites if they could understand the PBSPs, and all DSPs indicated that the plans were simple, clear, and easy to understand.	Substantial Compliance
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 parties agreed the monitoring team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because the facility had made limited progress. The noncompliance finding from the last review stands. The monitoring team observed a staff training, but did not review any documentation of training of staff in the implementation of PBSPs. As reported in past reviews, the monitoring team found the training to be thorough.	Noncompliance

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	the specific PBSPs for which they are responsible and on the implementation of those plans.	In order to meet the requirements of this provision item, LSSLC will need to present documentation that every staff assigned to work with an individual, including float/relief staff, has been trained (in a manner similar to that conducted by the behavioral health services department) in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	
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.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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, 5/15/13 o DADS Policy Preventive Health Care Guidelines, 8/30/11 o DADS Policy #006.2: At Risk Individuals, 12/29/10 o DADS Policy #09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044.2: Emergency Response, 9/7/11 o LSSLC Medical Care Policy, 9/1/13 o LSSLC Operation Procedure, Medical -05, Out of Hospital DNR, 11/15/13 o LSSLC Operational Procedure, Medical 04, Death of A Person Served, 11/1/13 o LSSLC Operational Procedure, Medical 14, Hospice Care, 7/1/13 o LSSLC Operational Procedure, Medical Care -02 Integrated Clinical Services, 10/1/12, revised 6/18/13 o LSSLC Operational Procedure Medical -19, Process for On Campus/Off Campus Consultations and Treatment Procedures o LSSLC Facility Operational Procedures Manual Committee and Councils -12, Clinical Services Morning Meeting, 1/24/12, revised 6/1/13 o Clinical Daily Provider Meeting Minutes o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o APRN Collaborative Agreement o Mortality Review Documents o External Clinic Tracking Log o Internal Clinic Tracking Log o Listing, Neurology Clinics o Internal and External Medical Reviews o Listing, Individuals with seizure disorder o Listing, Individuals with history of status epilepticus since last compliance review o Listing, Individuals with diagnosis of refractory seizure disorder o Listing, Individuals with VNS o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders

	o Listing, Individuals with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD o Listing, Individuals hospitalized and sent to emergency department o AED Polypharmacy Data 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 #286 Individual #344Individual #551, Individual #267, Individual #258, Individual #201 Individual #532, Individual #22, Individual #582, Individual #86 o Annual Medical Assessments the following individuals: • Individual #308 Individual #273, Individual #221, Individual #591Individual #119, Individual #354 Individual #435 Individual #122, Individual #117 Individual #199 Individual #469, Individual #187, Individual #506, Individual #86, Individual #494 o Neurology Notes for the following individuals: • Individual #308, Individual #144, Individual #27, Individual #423 Individual #469, Individual #187, Individual #437, Individual #124, Individual #428, Individual #120 <u>Interviews and Meetings Held</u>: o Andra Self, Clinical Services Director o Brian Carlin, MD, Lead Physician o Tammy Nelson, LVN, Medical Compliance Coordinator 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 Medication Variance Meeting o Polypharmacy Committee Meeting o Pharmacy and Therapeutics Committee Meeting o Pretreatment Sedation Committee Meeting o ISP for Individual #551
	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 the self-assessment was completed by the medical compliance coordinator who assumed the position on 10/1/13. The self-assessment listed

	a number of activities that were completed to assist in determining a self-rating. For each provision item, the MCC provided a series of activities engaged in to conduct the self-assessment, the results of the activities, and the overall self-rating for the provision item. While the self-assessment covered many elements that are reviewed by the monitoring team, the metrics were not the same or key metrics were omitted. For example, in assessing compliance with consultation documentation, the metric appeared to be documentation "on the consultation or it was documented in the IPN." The requirement is for IPN documentation. Another item addressed DNRs, but not determining if there was a rationale for continuing or discontinuing the order. The result was that all were current. However, explanations were not provided for all DNRs. A thorough self-assessment will require the inclusion of several quality metrics. Some components of quality require peer evaluation. LSSLC will require medical input in this process if the self-assessment is to serve as a valid and reliable assessment tool. The content of this report provides information on the types of activities and metrics utilized by the monitoring team. The facility rated itself in noncompliance with all four provision items. The monitoring team concurred with the facility's self-rating of noncompliance.
	Summary of Monitor's Assessment: There was little progress seen in the provision of medical services. Facility management was well aware of the lack of progress, particularly in L1. The facility continued to lack the medical leadership that was needed to establish the clinical standards of care, promote the quality of care, provide oversight to the medical quality program, and provide leadership and mentoring to the clinical staff. The medical department was fully staffed with four full time providers. Participation in the annual ISPs remained relatively low. Although it was reported to improve to 87% in September 2013, this translated into medical staff participation in three of 25 ISPs for the month. This was a relatively low number for a facility with individuals with complex medical needs. Facility data showed improvement in the timely completion of AMAs, but the actual date of completion of the AMAs was not clear. Signature dates, dates of assessment, and exam dates often differed by many weeks. Records included unsigned AMAs. The quality and content of the AMAs varied among the providers. Overall, more information was provided in the AMAs. IPN documentation varied among providers. It was well done by some providers, but for others it was inadequate and barely legible. Acute care documentation frequently involved only one note and documentation of the resolution of acute conditions was infrequent. Some providers utilized a four-line format for SOAP notes, which resulted in very few words and little information about the acute conditions. Providers did a good job of acknowledging the recommendations of the consultants; however, the specific requirements for documentation were not always met.

	The facility had an immunization nurse and this appeared to be very effective in ensuring that individuals received appropriate immunizations. The database included information on antibody titers for hepatitis B and varicella. Individuals received the necessary core immunizations. There was also documentation of appropriate screening of hearing. Most individuals also appeared to have timely routine eye exams. More than 90% of individuals who qualified for colonoscopy had completed the screening. The facility continued to screen males for prostate cancer with PSAs with 99% compliance. Screening for breast cancer needed some improvement. Overall, very few women had cervical cancer screening. Screening may not be appropriate for some females at the facility, but there was little documentation of the appropriate assessment to support the decision not to screen. Pneumonia continued to present challenges. There was no good system to review individuals with a history of pneumonia in order to appropriately classify each event. In the absence of a systematic review, most incidents of pneumonia were classified as bacterial. Even so, for the individuals who had recurrent pneumonia, of any type, there was little evidence that appropriate diagnostics and interventions were implemented to minimize recurrence. The monitoring team found incidents of pneumonia that were not included in the pneumonia data. Data issues were seen in several areas. Discharge diagnoses were not always consistent with the findings in the active records. One notable omission of a diagnosis involved Individual #556 whose hospital diagnosis was listed as misplaced g-tube**.** The daily clinical services meeting minutes actually indicated that this individual had a colectomy. The reason for the procedure was not stated in the minutes, but certainly, hospital data should have included an important diagnosis, such as colectomy. The facility completed external and internal reviews as required. Corrective actions were implemented and follow-up was done in most areas. The medical staff was also made aware of the audit findings and the areas that required attention. Minimum common elements of care were developed in several areas. The medical compliance coordinator was in the process of developing clinical indicators and audit tools that could be used as part of the medical quality program. It appeared that development of a medical quality program was proceeding without participation of the medical staff. Mortality reviews were completed as required. The absence of clinical leadership resulted in a lack of an objective review of the medical care. Consequently, the recommendations generated by the death reviews focused on nursing care. The medical department updated a number of policies and procedures. The clinical services director maintained documentation of the training that was provided to the medical staff for medical and non-medical topics. While there were a number of adequate policies and procedures in place, there was an outstanding need to develop local policies based on state issued clinical guidelines. The department also needed to clearly define the fundamental duties and responsibilities of the primary care providers in written policy.

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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. Each member of the primary care providers was assigned a licensed vocational nurse to provide additional support. The average caseload for the physicians was 90. The APRN's caseload was 71. The agreement between the APRN and physicians was both current and adequate. Given that each PCP was provided a nurse, these caseloads would appear manageable. LSSLC continued to function without a facility medical director. A clinical services director was hired in March 2013 to provide administrative oversight for the medical, pharmacy, psychiatry, and dental departments and the former medical director continued to serve in the role as lead physician. However, he reported that at no time was he ever provided a description of the duties and responsibilities of the lead physician. As a physician II, he was not aware of supervisory responsibilities for the other primary care providers and respiratory therapists. Upon further inquiry, the monitoring team determined that the facility had not created a job description for the position of lead physician. There was also no adequate delineation of the responsibilities of the primary medical providers defined in policy and procedure or in the job descriptions reviewed. A description of functions of the lead physician was submitted to the monitoring team following the compliance review. The medical compliance nurse position was filled on 10/1/13 by the medical department's former administrative assistant who was an LVN. As the medical compliance coordinator, she was assigned a number of duties related to collecting and monitoring data as well as development of clinical indicators and various audit tools. She functioned in other roles, such as the trainer for suction toothbrushing and medical transcriptionist. She was also responsible for ordering durable medical supplies. It appeared that these duties expanded beyond those of the medical compliance coordinator and could potentially limit the effectiveness of the position.	Noncompliance

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		Physician Participation In Team Process Daily Clinical Services Meeting The facility continued its daily clinical services meeting. The medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, habilitation staff, and psychologist attended this morning review. The events of the past 24 hours were discussed, including hospital admissions, consults, dental restraints, medical restraints, and off-campus appointments. Pretreatment sedation was discussed on Tuesdays and Thursdays. The minutes reviewed by the monitoring team provided detailed information related to hospitalizations, campus calls, clinic appointments, and other issues. This information was valuable, but the monitoring team noticed that few questions were actually asked during the actual meetings. The consults were read each day, but generally there were no questions asked related to this information. Lab values and other results reported during the meetings should stimulate discussion of care issues. One particular concern that arose from the review of the meeting minutes was the finding that multiple individuals with enteral tubes appeared to have hypernatremia (with variable volume status) upon admission to the hospital even though the provision of water was controlled by facility staff. ISP Meetings The monitoring team requested documentation of PCP attendance at the annual ISP meetings. Data for the months of June 2013 through December 2013 were submitted and are summarized in the table below. Primary Care Provider ISP Attendance 2013 | | No. of ISPs | Meetings Attended | Meetings Attended (%) | |---|---|---|---| | Jun | 33 | 6 | 18 | | Jul | 32 | 6 | 19 | | Aug | 32 | 3 | 9 | | Sep | 25 | 3 | 12 | | Oct | 36 | 10 | 27 | | Nov | 19 | 3 | 15 | | Dec | 28 | 6 | 21 | The clinical services director reported that PCP attendance at the annual ISPs had improved. This was based on the number of meetings that the PCPs were requested to attend. This was reported in the self-assessment to increase to 83% in September 2013, however, the monitoring team noticed that the total number of ISPs documented in the	

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		self-assessment differed from that submitted in documents provided after the compliance review. Nonetheless, 83% compliance reflected participation in three ISPs during the entire month. Given the medical complexity of the individuals living at the facility, there should be further investigation into the criteria for requesting PCP participation. The monitoring team attended the ISP of Individual #551. The meeting was well attended with representatives from all areas. This individual had a complex medical history that was complicated by poorly controlled seizure disorder that required multiple medication changes. Much of the discussion focused on the individual's history of somnolence and how the inability to remain alert for more than a few minutes was a barrier in achieving goals and allowing the individual to engage in preferred activities. The individual's entire outcome/plan was altered rather than there being discussion what actions should be taken to positively impact health outcomes and increase alertness, so that this individual might experience a better quality of life. **Overview of the Provision of Medical Services** The primary care providers 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. 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. Throughout the week of the compliance review, the monitoring team had an opportunity to observe and interact with the medical staff in a number of settings. They completed rounds and assessments and attended a number of meetings. It appeared that they worked to serve in the best interest of the individuals. There was evidence that they responded to the needs of the individuals. However, for some providers there appeared to be barriers in transitioning to new approaches that were required to fulfill some aspects of the Settlement Agreement. Many of these requirements were based on standard practices. The clinical services director was helpful in providing administrative guidance, but a clinical leader, such as a medical director, was needed to promote the standards to which all clinical staff were expected to adhere.	

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		The lack of clinical leadership resulted in the persistence of problems that have been observed for several years. Record reviews indicated that there were times when acute medical problems arose and it appeared that there was some type of physician intervention based on new orders or a comment in the nursing notes. However, it was not unusual to find no medical documentation by a primary provider. It was, therefore, not clear if the physician conducted an actual evaluation and if so what the findings and plan of care were. The monitoring team found several examples in which individuals experienced acute problems, during normal work hours, and were transferred to acute care facilities, but there was no documentation of evaluation by a primary provider. Follow-up care at LSSLC remained problematic. There was continued evidence that individuals returned from the hospital after prolonged stays, were seen by a PCP who documented a post-hospital note in the IPN, but did not provide any additional documentation of follow-up until there was a new problem. The monitoring team did not find evidence of adequate plans for management of individuals with repeat episodes of pneumonia. The decision to classify the majority of pneumonias as bacterial seemed unusual because some individuals had a history consistent with aspiration. However, individuals who experience frequent episodes of bacterial pneumonia also require a thorough and adequate workup for "recurrent pneumonia." Many individuals appeared to receive iron supplementation for treatment of anemia without any evidence of iron deficiency, or iron supplementation was started prior to the initiation of an anemia work-up. Individuals with normal hematocrits received supplementation without assessing the need for continued use or documentation of the source of iron loss. Several individuals in the record sample were also noted to develop pressure ulcers. The primary care providers documented very little with regards to staging and management. LSSLC did not have protocols for management of pressure ulcers. Checklists were not utilized to standardize assessments to ensure that all relevant areas were addressed, such as documentation of nutritional status, provision of pressure relief, and determining the need for bone scans when wounds healed slowly. Problems were identified with lab monitoring for the use of psychotropics and AEDs. Drug levels and labs were frequently not done in accordance with the lab matrix. Consultants sometimes noted the absence of recent drug levels. Some providers appeared to depend on the annual glucose and opted not to check HbA1cs even when individuals received multiple drugs that put them at risk. Several individuals should be	

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		re-evaluated because records indicated that in some instances, three or more criteria were present and this information had not been assimilated in a manner to emphasize the possibility of the diagnosis of metabolic syndrome. Overall, there was evidence that some good care was provided that benefitted the individuals supported by the facility. There were also examples of delayed follow-up and failure to follow-up on the medical care provided. The various sections of this report will provide examples of both the high and low points noted during this review. The case examples provide details related to the types of deficiencies discussed throughout the report. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 10 of 10 (100%) records included an AMA • 10 of 10 (100%) AMAs were current • 9 of 10 (90%) AMAs included comments on family history • 9 of 10 (90%) AMAs included information about smoking and/or substance abuse history • 9 of 10 (90%) AMAs included information regarding the potential to transition The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous year assessment. For the sample of Annual Medical Assessments submitted by the facility: • 15 of 15 (100%) AMAs were completed in a timely manner. • 15 of 15 (100%) 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	

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		The AMA was considered timely if it was completed within 365 days of the previous summary. It was obvious that the dates on the assessments were not accurate. For example, for Individual #506, the official assessment date was 10/3/13. The list of medical clinic visits documented in the assessment indicated that the annual physical exam was completed on 10/8/13. The same assessment also included data related to a podiatry visit completed on 10/11/13. For Individual #354, the assessment date was 10/2/13. Again, there was documentation within the assessment of a medical clinic visit on 10/14/13 and a cardiology appointment that was completed on 12/18/13. There was evidence that a number of the assessments reviewed were completed days to weeks later than the completion date listed on the document. The majority of the assessments submitted were not signed or dated by the providers. For those that were signed, many had signature dates that varied by more than 30 days from the assessment date. The monitoring team saw several AMAs that were transcribed three to four weeks following dictation. One extreme example was the case of Individual #22 whose AMA was dictated on 3/18/13 and was transcribed on 5/31/13. The AMA for this chronically ill and medically complex individual was, therefore, not available to the IDT until after 5/31/13. This is not an acceptable practice. The Annual Medical Assessment is complete when the physical examination, assessment, and plan have been completed and typed by the provider or submitted for transcription. Completion of a physical examination alone does not equate to completion of the annual medical assessment. In cases were the document is transcribed, the facility should provide services sufficient to ensure transcription occurs within 72 hours. <u>All medical dictations</u> should note the date that the document was dictated, the date transcribed and the initials of the transcriber. The times should be documented as well. The format of the AMA was complicated and in some sections appeared repetitive. A great deal of information was included in the assessments, but it was not always easy to get an overview of the health status. The adequacy of the plans varied among the providers. One provider who used the new template listed the problem, the status of the problem as active, and provided no plan of care to address the problem. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were being completed as required by the Health Care Guidelines by some medical providers	

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		For the records contained in the record sample: • 9 of 10 (100%) records included current QMSs • 9 of 9 (100%) summaries utilized the state template The QMSs completed were done using a state issued template. The content of these reviews was generally good and included information on recent hospitalizations, medication changes, abnormal labs, drug levels, radiograph test results, and recent consults. Content was however very provider specific. There were summaries that failed to document important information, such as abnormal lab values and significant weight loss that required intervention, but did not receive any attention from the PCP. The active problem information was repetitive and increased the length of the summary. Given the complex medical histories of many individuals, the list of problems may be extensive. Since the QMS provides supplemental interval information to the AMA, it may be possible to limit the problem list to diagnoses that involve some change in status. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL The APLs were found in all of the active records. Some of the documents were current and others were not. Most APLs had some degree of updates. This was an improvement from previous reviews. <u>Integrated Progress Notes</u> Physicians generally documented in the IPN in SOAP format when the entry involved a clinical encounter. The notes were usually signed and dated. Legibility of the notes was a significant concern with several providers. Problems with IPN documentation were not limited to legibility. The SOAP notes for several providers appeared to take a four line format with each entry being limited to one to three words. This format did not allow for compliance with the requirement to document the pertinent positive and negative findings for evaluations of acute conditions. In the majority of the records reviewed, documentation of acute medical problems never indicated resolution of the problem. The PCPs did an assessment, documented in the IPN, and in many instances, there was never a follow-up note. Similar documentation was frequently seen following hospitalizations. Documentation by the PCP prior to hospital transfer was rarely observed, even when the transfer occurred during normal business hours. At times, it appeared that the PCP may have been involved, but there was no documentation to substantiate the care. Documentation submitted by the clinical services director indicated that the PCPs were aware of the requirements for IPN entries, however, there	

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		was no improvement seen in this area. Physician Orders Physician orders were usually dated, timed, and signed. There were several concerns related to medication orders at LSSLC, including incomplete orders, orders lacking indications, and illegible orders. Physician orders were frequently noted for treatments in the absence of documentation of an appropriate evaluation. Medication orders are discussed further in section N1. Consultation Referrals The primary providers were required to provide adequate information to the consultants. It was difficult to assess the adequacy of data because all consults indicated that the pertinent information was attached. Consultants did note on several consults that information was missing, including laboratory studies, seizure data, and other diagnostics. It was sometimes indicated that the consultant was not certain of the reason for the consult. The medical staff documented consultations in the IPN. Overall, the documentation of the recommendations of the consultants continued to show a marked variation among the providers. 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. Almost all consultation forms indicated the appropriate review by the primary provider. IPN documentation presented a more challenging problem. The facility director reported that all primary providers utilized the IPN template that included all necessary components of documentation. However, one provider continued to write four line SOAP notes referring the reader to "see consult." This form of documentation was seen in entries made as recent as January 2014. Other providers utilized the template to varying degrees of success. There were entries that were complete and met all requirements. In other instances, it was clear that the information was being entered by someone other than the provider and the information was not sufficient to meet the documentation requirements. In those cases, (1) the documentation provided little information to the IDT, (2) the dates of the consultations were not entered, (3) three or four words were usually noted, and (4) the comments section referred the reader to the consult for further details. For example, for Individual #267, the IPN entry for a Hematology-Oncology consult should have summarized the significance of the consult. Instead of doing that, the entry noted that the individual was admitted to the hospital for pneumonia and respiratory insufficiency. When properly	

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		executed, this format had the ability to meet the documentation requirements. Consultation referrals are discussed further in section G2. **Routine and Preventive Care** Routine and preventive services were available to all individuals at the facility. Hearing screenings were provided with high rates of compliance. Most individuals had documentation of appropriate vision screening. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Documentation of varicella immunity was also very good. Compliance with colorectal and prostate cancer screening remained high. Compliance with breast cancer screening needed some improvement. Most females at the facility did not have cervical cancer screening. The lead physician reported they were not at risk because they had no history of sexual activity and exposure to the human papilloma virus. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 9 of 10 (90%) records included PCFSs • 8 of 9 (89%) forms included updates for 2013 The Preventive Care Flowsheets were found in 90% of the records reviewed. Most were updated. <u>Immunizations</u> • 10 of 10 (100%) individuals received the influenza vaccinations • 10 of 10 (100%) individuals had documentation of hepatitis B status • 10 of 10 (100%) individuals received the pneumococcal vaccination • 10 of 10 (100%) individuals received the Td vaccination • 9 of 10 (90%) individuals had documentation of varicella status <u>Screenings</u> • 7 of 10 (70%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing Data provided by the medical department included several individuals that did not have the most recent eye evaluations listed.	

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		Prostate Cancer Screening • 3 of 5 males met criteria for PSA testing • 3 of 3 (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 121 males: • 120 of 121 (99%) males had current PSA screening Breast Cancer Screening • 1 of 5 females met criteria for breast cancer screening • 1 of 1 (100%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 110 females, the date of the last mammogram, and explanations for any lack of testing: • 63 of 110 (57%) females had current screenings • 28 of 110 (25%) females had no reason for lack of current screening • 8 of 110 (7%) females had no screening due to body habitus • 3 of 110 (3%) females had no screening due to illness/home restrictions • 9 of 110 (8%) females had no screening due to guardian refusal, inability to cooperate, or other reasons Cervical Cancer Screening • 3 of 5 females met criteria for cervical cancer screening • 0 of 3 (0%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 138 females, the date of the last pap smear, and explanations for any lack of testing: • 55 of 138 (40%) females had gynecologic exams in 2013 o 5 of 55 (9%) females had total hysterectomies o 6 of 55 (11%) females were excluded due to age <21 or >65 o 4 of 55 (9%) females were not due for paps/refused o 1 of 55 (1%) females had cervical cancer screening o 39 of 55 (71%) females did not have cervical cancer screening • 32 of 138 (23%) females had gyn exams in 2012 o 5 of 32 (15%) females had total hysterectomies o 3 of 32 (9%) females were excluded due to age <21>65 o 7 of 32 (21%) females had cervical cancer screening o 17 of 32 (53) females did not have cervical cancer screen	

#	Provision	Assessment of Status	Compliance
		Overall, over a two-year period, 68 eligible women (excluding women with a history of hysterectomy and women outside of the age group) were referred for gyn exams. Cervical cancer screening was completed on 8 of 68 (11%) females. This appeared to be an overall low compliance rate even when the more recent and less stringent screening guidelines were applied. The explanations provided on the listing were frequently not adequate and included explanations, such as "not indicated," "hymen intact," "not indicated by gyn," or "unable due to condition." Although infection with the human papilloma virus is the most important risk related to development of cervical cancer, the decision not to complete cervical cancer screening must take into consideration other risk factors. Colorectal Cancer Screening • 3 of 10 individuals met criteria for colorectal cancer screening • 3 of 3 (100%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list included 203 individuals: • 185 of 203 (91%) individuals had completed colonoscopies • 9 of 203 (4%) individuals had orders pending for evaluation • 6 of 203 (3%) individuals had no explanation for lack of testing • 3 of 203 (1%) individuals had refusal or prep problems **Disease Management** The facility implemented numerous clinical guidelines based on state issued clinical protocols. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. The management of chronic diseases is discussed below. Pneumonia The facility submitted a list of individuals who were diagnosed with pneumonia from June 2013 through December 2013. Data for that period are shown in the table below.	

Pneumonia 2013							
	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Aspiration	0	0	0	0	0	2	1
Bacterial	3	2	4	3	4	8	5
Viral	0	0	0	0	0	2	0
Total	3	2	4	3	4	12	6

#	Provision	Assessment of Status	Compliance
		As noted in the table, the vast majority of cases were documented to be bacterial. The monitoring team continues to have concerns about the classification of pneumonia at the facility. Individuals were often diagnosed with aspiration pneumonia while hospitalized, and the diagnosis was changed to a non-aspiration diagnosis upon return to the facility. In some instances that may have been appropriate. In other cases, there was no rationale for changes in the diagnosis. The last monitoring team report cited the case of Individual #129 who utilized a gastric tube for nutrition and had clear evidence of aspiration on 1/13/13. A chest roentgenogram obtained during hospitalization showed "extensive right pneumonia consistent with aspiration.'' Upon return to the facility, the diagnosis was changed to bacterial pneumonia. This individual experienced pneumonia again on 10/2/13 that was classified as bacterial. As documented in the previous compliance reports, LSSLC continued to lack an organized process for pneumonia review. The process of having a member of the medical staff trained in infectious diseases review chest x-rays and data make a determination and report this information to the infection control committee continued. The monitoring team requested written support of these reviews, but was informed that there was none. The facility did not utilize AVATAR to track pneumonia, therefore, relevant data, such as CXR findings, complete blood counts, sputum cultures, risk factors, nutritional source, and signs and symptoms of disease that could be useful in making a determination about the type of pneumonia were not available. The Infection Control minutes simply documented that a physician would review the cases of pneumonia within 24 hours and make a determination regarding the type of pneumonia. The minutes dated 10/24/13 included an attachment "Pneumonia Report." The report included clinical information similar to that included in the AVATAR reports. There was no documentation in the minutes of how this was to be used. Facility staff reported that the state medical services coordinator had provided a pneumonia checklist, but the facility had not implemented use of this checklist. In addition to the problems related to classification of pneumonia, it was also evident that the current system did not adequately capture all incidents of pneumonia. For example, a CXR done on 10/31/13 for Individual #551 showed a "mild left lower lobe infiltrate" consistent with pneumonia." An IPN entry on 11/4/13 by the PCP documented probable pneumonia and antibiotics were prescribed. However, this was not reported on the pneumonia list. For the reporting period of June 2013 – December 2013, there were four individuals who experienced multiple episodes of pneumonia: • Individual #357: July and November	

#	Provision	Assessment of Status	Compliance
		• Individual #562: August, November, and December • Individual #441: June and December • Individual #47: July and November A thorough review of the risks, clinical symptoms, and diagnostic results should be conducted for each individual to categorize, as best possible, the pneumonia event. Each of the individuals had significant risks for aspiration, however, each episode of pneumonia was documented as bacterial. Individuals who experience multiple episodes of non-aspiration pneumonia should have an appropriate assessment to determine the etiology of recurrent and/or persistent pneumonia. The facility must focus on the management of aspiration and aspiration pneumonia and assign a high priority to addressing the following: • The accuracy of the pneumonia data must be examined. • A Pneumonia Review Committee should be formally adopted and include a process for assessing and classifying pneumonia cases. Consideration should be given to development of a checklist to review every case of pneumonia. The checklist would attempt to better define an individual's risk and determine the likelihood of an aspiration event. This can only be accomplished through a rather rigorous review of risk, diagnostics, and the clinical events that occurred prior to the onset of illness. • A process to ensure that every episode of pneumonia is captured should be developed. This may involve a monthly review of multiple data sets, such as a list of all individuals who received antibiotics for the diagnosis of pneumonia. This is necessary because not all individuals with a diagnosis of pneumonia are hospitalized or sent to the emergency department. • A comprehensive set of guidelines is needed to provide guidance to the medical staff on the management of recurrent aspiration. <u>Osteoporosis</u> A list of all individuals with osteoporosis and osteopenia was provided 193 names. • 147 individuals were diagnosed with osteoporosis o 130 of 147 (88%) individuals received calcium supplementation o 96 of 147 (65%) individuals received Vitamin D o 51 of 147 (34%) individuals received pharmacologic therapy such as bisphosphonates ▪ 17 of 51(33%) individuals did not have current DEXA scans o 66 of 147 (44%) of individuals did not have current DEXA scans • 46 individuals were diagnosed with osteopenia	

#	Provision	Assessment of Status	Compliance
		o 40 of 46 (86%) received calcium supplementation o 30 of 46 (65%) received Vitamin D o 11 of 46 (19%) received pharmacologic therapy, such as bisphosphonates o 10 of 46 (21%) of individuals did not have current DEXA scans A relatively small percentage of individuals with the diagnosis of osteoporosis received any treatment other than calcium and Vitamin D supplementation. For those who actually received additional pharmacologic treatment, 33% were not followed appropriately with DEXA scans to determine if the therapy was effective. <u>Hypertension</u> The facility did not have any guidelines or protocols for the management of hypertension. The lab matrix required an annual CBC, CMP, UA, and EKG. Monitoring of blood pressures and heart rates were at the discretion of the physician. The annual UAs to detect urine microalbumin were not consistently done. It was also noted that several individuals with hypertension were on diuretics. This would require monitoring of electrolytes more frequently than annually. The record of Individual #267, who received propanolol for treatment of hypertension, documented that the individual became bradycardic and lethargic after receiving a dose of propanolol. It was documented that there was no pulse check prior to administration of the medication. It is highly recommended that the facility develop guidelines for management of hypertension based on JNC August 2014 guidelines. <u>Constipation</u> A list of individuals with the diagnosis of constipation and the medications used was requested. The facility submitted an 87-page drug order report rather than the listing. This report documented that many individuals received multiple medications, in some instances four or five, for the management of constipation. The records documented many examples of individuals who were reported to have a lack of bowel movements for three days and therefore required acute interventions, such as suppositories and enemas, and several individuals required hospitalization related to the diagnosis of ileus. The primary providers should ensure that medications contributing to constipation are minimized and eliminated when not necessary.	

#	Provision	Assessment of Status	Compliance
		Case Examples Individual #267 • This individual had multiple hospitalizations in 2013. In January 2013, the individual was hospitalized for a contact allergic reaction to an unknown substance, and fever. There was a prolonged hospitalization for three weeks in February 2013 for pneumonia. In November 2013, the individual was again hospitalized with pneumonia and Influenza. • The AMA for this individual was completed on 3/28/13 and was transcribed on 4/20/13. Even though this individual had a history of recurrent aspiration, the AMA did not discuss the factors that increased risk and how the risk factors could be mitigated. There was also no specific plan of care to address aspiration. The plan of care was to continue current treatment. The Quarterly Medical Summary did not include important information, such as the development of a new pressure ulcer. The most recent QDRR was completed in June 2013. • There was minimal lab monitoring for this individual who received psychotropics and AEDs. The active record included a CMP dated 1/7/14 that documented abnormal values including Na 132, Cl 89, and CO2 36. There was no documentation in the IPN to address these values nor were there any follow-up studies in the record. There was no HbA1c even though it appeared that a glucose was obtained only annually, with the last being 102. The individual received valproic acid and levels were not monitored in accordance with facility protocol. • The individual had a history of anemia and thrombocytopenia and was evaluated by Hematology-Oncology who noted that iron studies were normal and anemia could possibly be medication related. The monitoring team could not determine if the individual had been started on iron supplementation prior to the iron studies being obtained. Clearly, this would affect the results. The indication for the use of iron supplementation in this individual remained unclear. Apart from this, this individual had a history of chronic significant constipation, sigmoid volvulus, and required four medications and multiple acute interventions. Appropriate bowel management would include elimination of any unnecessary drugs that contributed to constipation. • The individual had gynecomastia documented on CT scan. This was not documented on the physical examination, but was listed as an inactive problem. The etiology, drug related or undetermined, should be documented, and was not. • Many gaps were noted in the documentation in the active record. The individual developed a gluteal pressure ulcer. Documentation on 5/24/13 by the PCP simply noted pressure sore - buttocks; wound care. There was no documentation of the size or depth to assist in staging. There was no information on the specific care to be provided or additional supports, such as	

#	Provision	Assessment of Status	Compliance
		pressure relief. There was also no documentation of follow-up by the PCP. Nursing documented, on 5/30/13, the presence of an unstaged right foot wound. Another PCP entry, on 7/29/13, documented skin rash, buttocks sores, and anemia - ferrous sulfate. There was no documentation of why the decision was made to use ferrous sulfate, such as evidence of iron deficiency from blood loss or even inadequate intake. On 8/26/13, the PCP documented a skin rash, and sores to the buttocks and coccyx. Bedrest was ordered. There were follow-up evaluations weekly, but no evidence that the individual was referred to the wound clinic. • On 11/20/13, the individual was transferred to a nearby hospital for oral surgery. Surgery was cancelled due to the presence of fever and the individual was subsequently sent for labs and a CXR. The individual returned to LSSLC where nursing documented coarse breath sounds, bluish finger tips, and a O2 saturation of 83% on room air at 12:30 pm. The CXR showed pneumonia and the individual was transferred to the local hospital and admitted. • The individual retuned to the facility on 12/3/13. On 12/4/13 at 4 pm, the PCP documented a post hospital note in the IPN. There were no vital signs included in this entry and there were no additional follow-up notes. The next PCP entry was on 12/18/13: o S- pinkeye O- OU A - Conjunctivitis P - Gent OPH C+S There was no follow-up for this acute condition. The culture of the eye drainage was positive for methicillin resistant staph aureus. • On 12/26/13, the PCP documented in the IPN that blood was suctioned from the mouth of the individual. The assessment was "GI bleed?" A CBC was ordered. The record did not provided any follow-up of this evaluation. The IPN documentation was four lines and did not provide any explanation of why a GI bleed was considered. Acute gastrointestinal bleeding requires immediate medical attention usually in an acute care facility. Based on the documentation in the records, the CBC was collected on 12/30/13. There was no explanation for a four day delay in obtaining a CBC. • On 1/6/14, the PCPC documented the following: o S- ↑Temp o O - 100.6 with other symptoms o A - URI o P - Tamiflu, UA/C&S, SMA, CXR, Waters, 2 Abd Results were documented on 1/15/14.	

#	Provision	Assessment of Status	Compliance
		Individual #22 • This individual had multiple hospital admissions. In August 2013, the individual was hospitalized with sepsis, seizures, small bowel obstruction, and hypovolemia. In December 2013, the individual was admitted twice. The first admission was due to aspiration, hypovolemia, and hypernatremia. The second admission was for aspiration. • The AMA was completed on 3/18/13 and transcribed on 5/31/13. The AMA in the active record was unsigned. • IPN entry on 11/5/13 documented the results of the endoscopy completed on 11/1/13 and the need to continue PPIs. On 11/19/13, the PCP noted that the individual was not doing well and was refusing meals and was being sent to the ED for evaluation. The individual was diagnosed with dehydration and a UTI and returned to the facility. On 11/21/13, the PCP noted decreased activity and encouraged fluids. There was no follow-up documented. On 12/2/13, the individual was transferred to the ED due to intractable seizures and poor intake and was admitted until 12/10/13 with aspiration and hypovolemia. Labs were consistent with volume depletion and acidosis with Na 150, K 5, CO2 17, and BUN 23. There was no evidence of PCP evaluation prior to transfer. • IPN documentation upon retune was on 12/11/13. On 12/12/13, PCP documented fever 101, CXR, and ABX. There was no additional medical documentation • On 12/14/13, the individual was sent to the Emergency Department again, admitted, and discharged on 12/27/13. The PCP post hospital note on 12/28/13 provided no summary of the hospitalization. The assessment was "stable, S/P pneumonia." The plan was to continue present care. Notes on 12/30/13, and 12/31/13 documented. On 1/5/13, the decision was made to discontinue Keppra due to the continued agitation and SIB. On 1/10/14, a rash on the arm was documented with a plan to observe. On 1/13/14, left eye conjunctivitis was diagnosed. The individual was hospitalized again on 1/14/14. • This individual experienced a significant weight loss, yet this was never addressed. The Quarterly Medical Summary, dated October 2013, documented the last three weights ranged from 151 - 161 lbs. The annual nutritional assessment noted a weight in September 2013 of 131 lbs. with a weight in March 2013 of 158 lbs. This represented a 27 lb. weight loss. Weight records did show a gradual increase during the November 2013 to January 2014 to 142 lbs. The documentation above reflects essentially every IPN from November 2013 to January 2014 entry made by the medical providers for this individual who	

#	Provision	Assessment of Status	Compliance
		had multiple hospitalizations and ED visits. In most cases, there was little documentation of follow-up care by the providers. This individual had a series of abnormal lab results dating back to October 2013 that were evidence of the seriousness of the volume depletion. These were not addressed in the IPNs by the primary providers. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 152 individuals. A separate document pertaining to AED polypharmacy was also submitted indicating that a total of 167 individuals received AEDs for seizure disorder. Those data are summarized below: • 55 of 167 (33%) individuals received 1 AED • 61 of 167 (37%) individuals received 2 AEDs • 35 of 167 (21%) individuals received 3 AEDs • 12 of 167 (7%) individuals received 4 AEDs • 4 of 167 (2%) individuals received 5 AEDs The facility continued to conduct an onsite neurology clinic. Neurology Clinic Appointments 2013 Jun 29 Jul 12 Aug 16 Sep 29 Oct 29 Nov 14 A total of 129 on-campus appointments were completed over six months. Two clinics occurred most months. The average number of individuals seen each month was 21, which was a slight increase from the last reporting period. An epileptologist with certification in clinical neurophysiology was conducting clinic once a month. The facility reported that 24 of 152 (15%) of individuals had refractory seizure disorder. This was an increase from the 13% reported during the previous compliance review. Nine individuals had undergone VNS implantation. Two individuals were being evaluated for VNS or alternative therapies. Two individuals were reported o have experienced status epilepticus since the last compliance review. The monitoring team requested neurology consultation notes for 10 individuals. Notes for 10 individuals seen in neurology clinic were submitted. These individuals are listed in the above documents reviewed section. The following is a summary of the review of	

#	Provision	Assessment of Status	Compliance
		the records: • 10 of 10 (100%) individuals were seen at least twice over the past 12 months • 8 of 10 (80%) individuals had documentation of the seizure description • 8 of 10 (80%) individuals had documentation of current medications for seizures and dosages • 7 of 10 (70%) individuals had documentation of recent blood levels of antiepileptic medications • 0 of 10 (0%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 10 of 10 (100%) individuals had documentation of recommendations for medications • 0 of 10 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The monitoring team was concerned about many issues related to the provision of care to individuals with seizure disorder: • Labs were not always available as required. • There was no indication that the MOSES and DISCUS evaluations were reviewed by, or even provided to, the consultants. • Collaboration between neurology and psychiatry was improving, but there was evidence that more discussions and coordination needed to occur. • Documentation of medication side effects was not always adequate. The impact of medications on the quality of life should be taken into consideration. There were examples of individuals who were lethargic when seen in clinic and one individual who was noted to sleep at each clinic visit. For the individual who was reported to continually sleep, there was no discussion of how the medications resulted in a poor quality of life and what alternative therapies could be explored to help this individual have the best health and quality of life that was possible. The following are some examples of concerns identified with regards to neurological care provided to the individuals supported by the facility: • Individual #308 had intractable seizure disorder. Management was complicated by a recommendation to increase Keppra, which did not occur for several months. The individual was subsequently hospitalized with status epilepticus and pneumonia. The neurologist documented during the May 2013 appointment that the psychiatry clinic nurse and RN case manager attended the appointment. In October 2013, the neurologist noted that the individual experienced behavioral issues and the epileptologist recommended discontinuation of Keppra. It was good to see that psychiatry participated in	

#	Provision	Assessment of Status	Compliance
		management of this individual. Earlier participation, however, may have prevented the use of Keppra and subsequent behavioral issues. • Individual #120 had a VNS and was seen in clinic on 6/12/13 with continued seizures. An EEG was requested. The individual returned to clinic on 7/10/13, a month later, at the recommendation of the treating psychiatrist due to continued seizures and falls associated with seizures. The fact that this individual was experiencing uncontrolled seizures and injuries should have resulted in expediting of the completion of the EEG. The EEG had not been completed. On 9/25/13, the neurologist noted the individual was in a wheelchair and continued to have seizures, falls, and a rib fracture. The EEG was completed. • Individual #469 had refractory seizure disorder. Ataxia improved with a decrease in carbamazepine, but seizures were poorly controlled with three medications. Staff reported increasing seizures and behavioral issues. On 5/8/13, due to poorly controlled seizures while on three medications, the individual was referred to the epileptologist for evaluation for VNS. On 8/28/13, the epileptologist documented that "unfortunately I do not have the seizure records available for my review." "Consider VNS and surgery." The individual was to return in three months, but there was no documentation of a follow-up visit in November 2013. The lack of information impeded the proper evaluation. • Individual #437 6/26/13 – The seizure log was not available in clinic. • Individual #144 had intractable seizures and a VNS. The consult dated 4/24/13 noted there were no recent Dilantin or Trileptal levels. The neurologist documented on 8/28/13 that it was unclear when his last interrogation of the VNS was done. The consultation note for 10/24/13 indicated that the individual had multiple hospital stays and increased seizure frequency. "I cannot get the exact number as I do not have the seizure graph or an updated seizure list here." **Access To Specialists** During the July 2013 review, it was noted that there were problems obtaining the results to some off campus consults. The facility implemented changes in several processes to address this problem. The medical compliance coordinator tracked all consults. Data were entered into a database, including the consult specialty, primary provider, time to consult completion, time to receipt of consult, missed consults, and reason. A report was run each Friday for presentation at the clinical morning meeting. This information assisted the PCPs in the development of corrective action plans. The revised procedure did not include a system for prioritizing appointments to ensure that those with the most need occurred first. Staff reported that this was not a problem and they rarely encountered difficulty finding providers to care for individuals in a timely manner.	

#	Provision	Assessment of Status	Compliance
		Do Not Resuscitate The facility submitted a list of individuals who had DNR orders in place. The list included nine individuals. Five of the DNRs were implemented in 2013, one in 2012, one in 2010, and one in January 2014. One individual had a long standing DNR implemented in 1994. The average age was 43.5 years with a range from 22 to 58 years. The qualifying conditions were listed as anencephaly, respiratory failure, cirrhosis, and seizures. No qualifying diagnoses were listed for Individual #298 and Individual #10 who had DNRs implemented at the request of the family. The documentation for these two individuals, as well as two other individuals, indicated that the DNRs were not applicable out of the hospital. However, copies of physician orders indicated that DNR orders were implemented at the facility. The monitoring team recommends that in those instances when out of hospital DNRs are considered for individuals with no clear medical justification, there should be a review by the Ethics Committee with input from state office to ensure compliance with state guidelines. <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: 1. The facility director should continue to recruit a medical director. 2. The current process for requesting physician attendance at ISPs should be reviewed to ensure that requests are being made for individuals whose health status has a significant t impact on the planning process. 3. Recommendations and comments discussed in the various sub-sections should be addressed.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Medical Reviews - External</u> An external medical reviewer conducted Round 8 of the medical audits 8/27/13 - 8/28/13. State guidelines required that a sample of records be examined for compliance with 46 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, all essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. A total of 19 records were reviewed for the general medical audit. The facility submitted data for the external audits. Those data are summarized in the table below:	Noncompliance

#	Provision	Assessment of Status	Compliance

Round 8 - General Medical Audits Compliance (%)		
	Essential	Non-essential
Round 8	83	89.75

Compliance scores were less than 80% for the following questions:

- Q2 – Is there evidence the Active Problem List was updated with each new problem?
- Q5 – Does the summary include significant medical events of current and past years?
- Q9 –Has the MMR immunization been given?
- Q14 Has the Varicella (titer or vaccine) been given?
- Q15 – Has the Zostavax (if >60yrs) been given?
- Q22 – Have the appropriate preventive screenings for PSA been provided?
- Q26 - Was the PCFS updated at the time of the last annual assessment?
- Q33 –Are responses to significant lab values documented in the IPN?
- Q35 –Are significant abnormal diagnostic tests results addressed by the provider?
- Q37 - Is the provider's documentation legible?
- Q39 - Do notes regarding acute medical problems contain pertinent positive and negatives?
- Q42 - Did the provider indicate resolution and closure of acute problem in the IPN?

In addition to the general medical audits, medical management audits were also completed. Six charts, three for each selected condition, were reviewed. The results are presented in the table below.

Round 8 Medical Management Audits		
	Constipation	Seizure
Aug 2013	71	94

Corrective action plans were developed by the QA department. A total of 93 action plans were developed and completed for the general external audit. Five action plans were developed for the medical management audits. According to data submitted the week following the compliance review, follow-up had not been completed by QA.

#	Provision	Assessment of Status	Compliance

Round 8 - Corrective Action Plans					
	Total Action Plans	Reviewed By QA	Remaining to Review by QA	Completed	Remaining to Complete
General Medical	93	93	0	93	0
Medical Management	5	0	5	0	5

The facility provided documentation of an inservice conducted on 9/26/13 with the medical staff. Primary care providers were informed of the audit process and findings. Information on the various requirements of the Healthcare Guidelines was also reviewed.

Overall, the facility completed the external review within the required timeframe, implemented corrective actions for identified deficiencies, and conducted follow-up of the corrective actions. The monitoring team did identify some issues with the process that require attention:

- A total of 22 records were audited with 19 of those records audited for general medical care. LSSLC would need to audit approximately 34 records every six months to meet the initial requirement of an annual sample size of 20%.
- State guidelines required that three specific conditions be reviewed for the medical management audits. The facility reviewed only seizures and constipation.
- The follow-up for the medical management audits remained incomplete as of January 2014.

<u>Mortality Management at LSSLC</u>
Nine deaths occurred in 2013, three of which occurred since the last compliance review. The average age of all deaths for 2013 was 63.3 years.

The mortality documents for the four deaths that occurred from June 2013 through September 2013 were reviewed. Information for those deaths is summarized below:

- The average age of death was 63.5 years with an age range of 43 to 85 years.
- The causes of death were:
  - Respiratory failure, bilateral pneumonia
  - Respiratory failure, aspiration pneumonia, sepsis
  - Fatal ventricular arrhythmia, acute bronchopneumonia, aspiration of gastric contents, right atrial mural thrombus
  - Renal failure, diabetes mellitus
- Two autopsies were performed.
- Three individuals died during hospitalization.

#	Provision	Assessment of Status	Compliance
		The monitoring team met with the facility director, clinical services director, CNE, QA director, and QA nurse, to discuss mortality management at the facility. There was no physician present for the discussion of the mortality review process. The specific monitoring team concerns included the dearth of recommendations noted in the clinical death reviews. There was a continued need to have an objective review of medical care by a physician other than the primary care provider. This was particularly difficult for LSSLC due to the lack of a medical director. Facility staff reported that the Quantros review continued to be completed, but this information was received many months following the death. While recommendations generated by the death reviews were tracked, the overall mortality data did not appear to be linked to the facility's quality system. Three of the four deaths were related to pneumonia and several individuals were experiencing recurrent pneumonia, yet there had been no further exploration of this area. The monitoring team encourages the facility staff to enhance the mortality review process by: • Ensuring adequate information is reviewed (no less than one year of the records, and two if possible) • Ensuring that all hospital information is obtained for review • A comprehensive and objective review of the medical care should be completed by a physician, preferably one not associated with the facility. The physician should be trained in the area of primary care medicine. The findings and recommendations from the review should be summarized in a written report and presented during the clinical death review. <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: 1. The medical audits must be completed in accordance with state guidelines and provide clear documentation of the methodology. 2. Corrective actions should be tracked in a timely manner and appropriate documentation maintained of the tracking. 3. There should be evidence that data are utilized by the medical department for the purpose of performance improvement. 4. Mortality management should be addressed as noted above.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>L3</td><td>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.</td><td>
<u>Internal Medical Reviews</u>
Round 8 of the internal medical audits were completed in August 2013. The results are presented in the table below.
<table>
<tr><th colspan="4">Round 8 - General Medical Audits
Compliance (%)</th></tr>
<tr><td></td><td></td><td>Essential</td><td>Non-essential</td></tr>
<tr><td>Aug 2013</td><td>Round 8</td><td>96</td><td>97</td></tr>
</table>
The external and internal audits for Round 8 were completed at the same time to allow for assessment of inter-rater reliability. There was a significant difference in the internal and external scores.

Medical management audits were also completed in August 2013. The findings for the six charts reviewed are listed below.
<table>
<tr><th colspan="3">Round 8 - Medical Management Audits
Compliance (%)</th></tr>
<tr><td></td><td>Constipation</td><td>Seizures</td></tr>
<tr><td>Round 8</td><td>85</td><td>100</td></tr>
</table>
Again, the audits indicated significant differences in the scores between the external and internal scores. The facility will need to address inter-rater reliability.

Corrective action plans were developed by the QA department. A total of 56 action plans were developed and completed for the general internal audit.
<table>
<tr><th colspan="6">Round 8 - Corrective Action Plans</th></tr>
<tr><td></td><td>Total Action Plans</td><td>Reviewed By QA</td><td>Remaining to Review by QA</td><td>Completed</td><td>Remaining to Complete</td></tr>
<tr><td>Round 8</td><td>56</td><td>39</td><td>17</td><td>28</td><td>28</td></tr>
</table>
At the time of the compliance review, follow-up on the corrective action plan had not been completed.

On 11/25/13, the facility completed another round of internal audits. A total of 19 charts were reviewed for the general medical audits and nine charts were reviewed for the medical management audits. The results are summarized in the tables below.
<table>
<tr><th colspan="4">General Medical Audits
Compliance (%)</th></tr>
<tr><td></td><td></td><td>Essential</td><td>Non-essential</td></tr>
<tr><td>Nov 2013</td><td>Round X</td><td>89</td><td>94</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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Medical Management Audits Compliance (%)			
	Constipation	Seizures	UTI
Nov 2013	100	70	100

Corrective action plans were developed. There were no data available on follow-up at the time of the compliance review.

Medical Quality Program

The clinical services director and medical compliance coordinator reported that minimum common elements of care were developed for several conditions, including aspiration, constipation, diabetes mellitus, enteral feedings, metabolic syndrome, osteoporosis, seizures, and UTI. The medical compliance coordinator was in the process of developing clinical indicators that could be utilized as part of the auditing process to determine compliance with clinical guidelines. This could serve as a start to the development of a medical quality program. This provision addresses the need to collect data related to the "quality of medical services," which requires assessing a number of areas.

At the time of the compliance review, the facility had no other defined systems to measure the quality of care provided. LSSLC maintained databases that included a number of data elements related to preventive care, hospitalizations, seizure management, and pneumonia. As noted in various sections of this review, the accuracy of data was a concern. There was no evidence that the medical department had a process to review, analyze, and trend this data for the purpose of identifying areas of strengths as well as opportunities for performance improvement. Given the lack of a medical director for some time, this was not unexpected. The facility must develop a comprehensive set of indicators that includes a mix of well defined and measurable process and outcome indicators. Development of a good set of indicators/metrics will result in data that help to determine the quality of care, highlight what areas need improvement, and provide an objective means of measuring the success of the interventions. Clinical leadership will be necessary for this requirement to materialize.

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 recommends the consideration of the following.

1. The medical management audits should be expanded to include additional conditions that require monitoring elated to the quality of care.

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		2. The facility must develop and implement a medical quality program. As recommended in the previous reports, the facility will need to develop a comprehensive set of indicators that includes a mix of process and outcome indicators. Clinical outcomes must be assessed as part of this process. 3. 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.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The monitoring team requested a copy of the complete medical policy and procedure manual including any other facility policies that were related to medical care. The following policies and procedures were submitted: • LSSLC Medical Care Policy, 9/1/13 • LSSLC Operation Procedure, Medical -05, Out of Hospital DNR, 11/15/13 • LSSLC Operational Procedure, Medical 04, Death of A Person Served, 11/1/13 • LSSLC Operational Procedure, Medical 14, Hospice Care, 7/1/13 • LSSLC Operational Procedure, Medical Care -02 Integrated Clinical Services, 6/18/13 • LSSLC Operational Procedure Medical -19, Process for On Campus/Off Campus Consultations and Treatment Procedures The following were submitted as new clinical guidelines: • Preventive Care Flow Sheet • LSSLC Operational Procedure, Pre-sedation Consultation Procedure, Medical - 18 The medical care policy was revised in September 2013. It was a broad policy that covered a number of aspects of medical services. It appropriately noted that the lead physician and clinical services director would review all medical policies on an annual basis and update as needed. One component that was notably absent was a description of the basic medical staff requirements and job duties such as caseload responsibilities, completion of clinical rounds, on-call coverage responsibility, and weekend coverage. The medical department needs a comprehensive medical manual that includes the relevant information related to operations of the department and provision of health care services. This would include, but not be limited to information on staffing and caseloads, the role of the PCP in the IDT process, requirements for participation in ISPs and ISPAs, and participation of primary providers in various meetings. Procedures related to delivery systems should be provided such as how consults are ordered, the process for obtaining labs, ordering x-rays and the various tracking systems.	Noncompliance

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		The requirements for the actual provision of care should also be included and cover acute care, preventive care requirements, and the expectations for the use of the various clinical guidelines and protocols. Much of this is addressed in existing policies and procedures. Another component of the manual would be the policies and procedures that describe the oversight processes, such as the internal and external medical reviews, the medical quality program, the mortality review process, and the facility's QA system. Other relevant policies, procedures, and guidelines, such as those related to the use of psychotropics, pharmacy services, and other integrated services should also be included. These official documents must include the issue/implementation date and be signed and dated by the appointing authority. The facility must also have a procedure in place to ensure that all policies and procedures undergo an annual review and are updated and revised as deemed appropriate. The facility provided training rosters for inservices completed for the policy revisions listed above as well as several other medical and non-medical policies and procedures. It appeared that this documentation was being consistently done since mid-2013. There was no documentation provided for the multidisciplinary state issued clinical guidelines and protocols. LSSLC had yet to develop local policies based on state issued clinical guidelines. <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: 1. The recommendations above should be addressed. 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, and other identified conditions. 3. Local policies should be developed based on state issued guidelines. 4. Each member of the medical staff should have a medical department policy and procedure manual that includes all relevant policies and procedures and guidelines. 5. The medical department should maintain written documentation of all training and inservices that are provided 6. The department should establish a system for annual review of all medical policies and procedures.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o LSSLC Section M Self-Assessment, Updated: 12/30/13 o LSSLC Section M Action Plan, Updated: 12/28/13 o LSSLC M Presentation Book o Active Record Order and Guideline o Map of Facility o LSSLC Nursing Services Organizational Chart, including titles and names of staff currently holding management positions o SSLC Comprehensive Nursing Assessment Review/Quarterly Nursing Record Review/Quarterly Physical Assessment Guidelines, 9/13 o SSSLC/LSSLC Nursing inter-office communication for Annual Comprehensive and Quarterly Assessment Audit Tools, Dated: 9/30/13 o SSLC/LSSLC Nursing inter-office communication for Acute Care Plan Template and Audit Tool, Dated: 11/18/13 o LSSLC Nursing Services Policy, #0713, 7/13 o LSSLC Nursing Care Plans Policy, Reviewed: 12/13 o LSSLC Nursing Protocol: Post Anesthesia Care, 6/10 o LSSLC Pretreatment and Post Sedation Monitoring, 12/10 o LSSLC Neurological Assessment, 1013, 2008, Reviewed: 10/13 o LSSLC Death of a Resident Policy, Revised 11/1/13 o LSSLC Out of Hospital DNR Policy, 11/15/13 o LSSLC Last six months Nursing Staffing Reports/Analysis o LSSLC Infirmary Daily Census Reports, 1/13/14 - 1/15/14 o LSSLC Pneumonia Report Form o LSSLC Physical Nutritional Management Policy, 6/1/13 o LSSLC Medication Variance Policy, 5/14/13 o LSSLC Medication Administration Procedure, #1113, Reviewed: 11/13 o SSLC Medication Administration Observation Form, 10/31/12 o SSLC Medication Room Audit Form, 7/27/12 o LSSLC Medication Room Audit, 12/13 o LSSCL Refrigerator /Room Temperature Monitor Records, 12/13 o LSSLC Listing of Unit Medication Administration Times o LSSLC Last six months Medication Variance Committee Meeting Notes o LSSLC last six months, number of medication variances by error type, discipline, home, unit individual, category of severity, and error mode o LSSLC last six months, any case analysis and/or reports addressing medication variance and any plans of correction o LSSLC Medication Administration Variance Committee Meeting Agenda, 1/15/14

	o LSSLC Last 10 Medication Variances and Plan of Correction o LSSLC Community Outings Policy, 11/5/13 o LSSLC Pharmacy and Therapeutics Committee Meeting Minutes, 7/10/13 and 11/7/13 o LSSLC Physical Nutritional Management Policy, 6/1/13 o LSSLC Executive Safety Committee Policy, Revised: 1/1/14 o LSSLC List of all individuals admitted to the facility and the length of stay, and diagnosis for infirmary admission o LSSLC Listing of individuals with Gastrostomy, Jejunostomy Tube or G/J tube, Tracheostomy, Colostomy, Ileostomy, Foley Catheter, and Port –A-Cath o LSSLC for the past year, a list of individual deaths by, date of death, time of death and cause of death o LSSLC Last six months Nurse Administrative Team Meetings, o LSSLC Nursing staffing reports/analysis for the last six months o LSSLC New Nursing Staff Orientation o LSSLC Nurse Competency Based Training Curriculum o LSSLC Last six months Nursing Education Calendar o LSSLC Nursing Competency Training Curriculum –Agency /Contract Nurses Policy #0513 o LSSLC Number and percentage of Nurses Trained Medication Administration, SOAP Documentation, Care Plan Development, Physical Assessment, Planning Care, Physical Assessment, Mosby's Course Class, Physical Assessment Courses, Preceptor Training, Annual Skills Competencies/Check off and Vascular Access Ports (VAP) Policy/Check-Off o LSSLC RN Case Management Monthly Meeting Minutes for the last six months o LSSLC Clinical Services Morning Meeting Minutes and associated documents 1/13/14 - 1/17/14 o LSSLC Pretreatment Sedation Minutes and associated documents, 1/14/14 o LSSLC CPR Mock Drill Summaries, 9/13 – 11/13 o LSSLC List of Locations of Emergency Equipment o LSSLC Medical Response and Drills, Revised: 1/16/14 o LSSLC Last six months Code Blue or medical emergency reports, code blue drill reports and analysis, logs, and CAPS o LSSLC Emergency Equipment Oxygen, Suction Machine Walkthrough Checklist 12/13 and 1/14 o LSSLC Automatic Defibrillator and Emergency Bag Checklist for o LSSLC Wound and Skin Integrity Meeting, Dated: 12/12/13 o LSSLC Last six months Antibiograms o LSSLC Infection Control Meeting Minutes and associated documents for last six months o LSSLC Infection Control for New Employee Orientation o LSSLC Environmental Safety Committee Meeting Minutes 6/20/13, 9/19/13 o LSSLC last six months Monthly Nursing Safety Meeting Notes o LSSLC Executive Safety Committee Minutes, 9/26/13, and associated documents o LSSLC Mortality Recommendations last six months o LSSLC Mortality Summaries 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 Last six months of QA/QI Meeting Minutes pertaining to Section M 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 o Last six months, medication administration observation audits, analysis reports, and associated plans of correction o Last six month, number of medication variances y error type, discipline, home, shift, unit individual, category of severity, and error mode o Last five individuals transitioned to the community completed nursing discharge summary and associated packets o Last six months Synopsis of Inter Rater Review Findings to be disseminated to auditors o Last six months nursing audits, analysis reports, plans of correction, for: vital signs, antibiotics, constipation, urinary tract infections, vomiting, nursing assessments, nursing care plans, acute illness and injury and eternal complications, falls, Infirmary, pain, primary provider contact, respiratory, seizure, and documentation o Records Reviews: Comprehensive Record Review, including MARs/TARs, selected from the Facility At Risk for high risk rated individuals from across campus as follows: Individual #551, Individual #27, Individual #203, Individual #120, Individual #185, Individual 361 #, Individual 174 #, Individual #241, Individual #106, Individual #354, Individual 591#Individual 413#, and Individual #383 o Community Nursing Discharge Summaries and Discharge Packets for: Individual #412, Individual #226, Individual #505, Individual #23, and Individual #138 o Hospital Liaison Reports, IPNs, and associated documents for: Individual #85, Individual #361, and Individual #22 o Hospital ER/LTAC Reports, IPNs, and associated documents for individuals o Medication Variances and associated documents for: Individual #45, Individual #36, Individual #370, Individual #527, Individual #50, Individual #573, Individual #218, and Individual #447 o Medication Administration Records, IPN, and applicable SAMs, Enteral Nutrition Records for: Individual #440, Individual #9, Individual #34, Individual #91, Individual #562, Individual #401, Individual #47, Individual #51, Individual #135, and Individual #110 <u>Interviews and Meetings Held</u>: o Mary Bowers RN, BSN, Chief Executive Nurse (CNE)/1/13/14 o Laura Bowers RN, BSN, Nursing Operations Officer (NOO) 1/13/14 o Christy Infection Control Nurse, Christy Pounders RN, MSN (ICP) 1/16/14 o Elizabeth Moody, RN, BSN, Immunization Nurse o Nurse Compliance Officer, Gerald Davis, RN (NCO) 1/15/14 o Nurse Educators, Zalinda Colston, RN, MSN and Joyce Adams RN, BSN o Tanesha Wilson RN, BSN, RN Case Manager Supervisor 1/16/14

	o Quality Assurance Nurses, Paul Vann RN, and La Donna Erwin-Brooks RN, BSN 1/16/14 o Sarah Heckendorn, RN, BSN, Hospital Liaison Nurse o Nurse Managers, Campus RN Supervisors, Staff RNs and LVNs <u>Observations Conducted</u>: o Residential areas at various time of the day and evening o Medication Room inspections at various time of the day and evening o LSSLC Wound Clinic Rounds o Medication Administration Observations for: Individual #440, Individual #9, Individual #34, Individual #91, Individual #562, Individual #401, Individual #47, Individual #51, Individual #135, and Individual #110 o Individual Support Meeting for Individual #551 held on: 1/14/14 o LSSLC Pharmacy and Therapeutic Meeting 1/13/14 o LSSLC Clinical Services Meeting 1/14/14, 1/15/14 and 1/16/14 o LSSLC Pretreatment Sedation Committee Meeting 1/14/14 o LSSLC Polypharmacy Meeting 1/14/13 o LSSLC Infection Control Committee Meeting 1/14/14 o LSSLC Skin Integrity Committee Meeting 1/14/14 o Individual Support Plan Meeting Individual #551 April Cardwell 1/14/14 o LSSLC Nursing Settlement Agreement Meeting 1/14/14 o LSSLC Medication Variance Committee Meeting 1/15/14 o Risk Management Meeting 1/15/14 o LSSLC Skin Care Inservice (Medline) 1/16/14 o Mortality Meeting 1/16/14
	Facility Self-Assessment: The facility submitted its self-assessment and action plans for section M, updated 12/30/13. The format was improved and aligned more with the monitoring team's topics. The self-assessment indicated, on 11/1/13, discontinuation of three protocol audit tools (Antibiotic Therapy, Constipation and Vomiting), and eight new tools (Enteral Compliance, Immunizations, Integrated Health Care Plan, Primary Care Provider Notification, Quarterly Assessments, Real Time Infections, Skin and Urgent/Care Hospital). The self-assessment did include a rationale for the changes. For the action plan, updated 12/28/13, content was scant regarding action steps initiated since the last monitoring visit, for provisions M1, M3, M4, and M6. M4 included a Corrective Action Plan (CAP) between Nursing and QA to address previous injury assessments with a start date of July 2013 and completion date of February 2014. However, M4 did not contain progress activities that addressed the action step.

	Summary of Monitor's Assessment: During the onsite monitoring review, the monitoring team visited all of the units, most of the homes, and some on a more frequent basis. The monitoring team conducted 30 unplanned medication pass observations for 10 individuals, observed five individuals during wound rounds, and visited nine of the 12 individuals selected by the monitoring team for detailed review. These rounds included encounters with over 50 nurses, including Nurse Managers, Direct Care RNs, LVNs, and RN Case Managers. For each of the units and homes visited, the monitoring team queried the nursing staff using different acute illness/injury scenarios and found correct response as to how the nursing staff would approach, document, and follow-up to resolution on the nursing problem. The facility staffing analysis did not include an acuity-based factor, which can be an important variable for ensuring that the individuals' complexity of care drives staffing plans. Nursing IPNs were consistently written in SOAP format and legibility of the nurses' handwriting had improved. The IPN nursing notes for individuals with acute changes in their health care status were not consistently documented when their problems were resolved, and/or the effectiveness of the interventions/treatments provided. The Hospital Liaison Nurse was present at the hospital during various times of the day, with a great deal of early morning hours spent at the hospital, in order to have direct communication with the physicians during their hospital rounds. The Infection Control Preventionist was instrumental in her surveillance of flu cases and fostered collaboration between the facility physicians and the local health department to develop plans for continued surveillance, implementation of contact isolation, and discussion of recommended treatment plans, which were followed by the facility. Overall, however, observations conducted by the monitoring team throughout the week on all the units, showed that infection control practices were problematic, even though training had been put in place. Acceptable Standard Precautions and hand hygiene had not been fully implemented. The facility had not been successful in achieving an acceptable zero rate for decubitus ulcers. There were three, of which two were reported as hospital-acquired. The CNE should collaborate with the Hospital Nursing Director to ensure there is ongoing communication when individuals are admitted from the facility with decubiti, and when individuals are admitted to the facility with decubiti. The facility should undertake a process to evaluate care issues associated with decubiti that occur at LSSLC. The facility also continued to maintain elevated numbers with soft skin infections. The facility should investigate the underlying reason for the trends occurring in units. A plan should be put in place to ensure that these unacceptable infection control practices do not continue. The monitoring team strongly recommends, especially due to the number of individuals who had decubitus as a result of their care/lack of care, and due to the number of individuals with stomas with device-

	associated procedures (e.g., feeding tube, ileostomy, Foley catheters), that the facility consider a certified RN Wound Enteral Stoma Nurse as a member of the nursing team. The facility infirmary should develop guidelines for admissions, discharges, and transfers. The facility should also examine its own data as to lengthy infirmary stays, hospital discharges, and emergency visits that resulted in a return to the hospital within 24 hours. The RN Case Manager Supervisor was to develop a process to ensure consistency among the Comprehensive/Quarterly/Nursing Assessments and their associated Integrated Health Care Plans. The monitoring team found an overall 78% rating for Nursing Assessments/Quarterly, which fell below the expected criteria of 90%. The quality and completeness of the ACPs showed little improvement; much work is needed here. The Nursing Department should provide over-the-shoulder monitoring in the implementation of health care plans to ensure consistency among the plans, and that the plans accurately reflect the individuals' problems/diagnoses. The plans should be individualized for the individual. The monitoring team suggests the State Nursing Coordinator develop uniform processes, in other words, instructions for the Discharge Summaries. For individuals requiring nursing procedures, ensure the summary documents, as applicable, how facility RN to community RN communication and/or training occurred. The degree of omissions in the application of nursing assessments, application of protocol cards, and implementation of plans of care indicated that training had not transferred into practice sufficiently to address the health status of the individuals. More time is needed for nurses to gain experience in the consistency of application of nursing assessment/physical assessment, use of the various protocols, and the requirements for reporting to the individual's primary care provider. The facility continues to require much work toward having positive and productive IDT meetings for the individuals ISP and their associated risk process. There was little improvement in the integration of risk among all of the disciplines. Regarding medication administration and variances, there was an absence of a fundamental medication safety system to ensure checks and balances in the completion of physician orders to resolution, a reliable system for medication reconciliation/verification of physician's orders, transcription of the orders, and administration of medications.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample) for this subsection because the facility had made limited progress. The noncompliance findings from the last review stands. The monitoring team conducted its own review of the requirements for section M through review of information presented in section M of the Presentation Book, review of documents requested, and meetings/interviews with Chief Nursing Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educators, Hospital Liaison Nurse, Infection Control Preventionist, RN Case Manager Supervisor, Nurse Managers, Direct Care Nurses, and Quality Assurance Nurses. <u>Staffing, Structure, and Supervision</u> At the time of the review there were 338 individuals residing at LSSLC. As reported in the facility's data, the total number of nurses budgeted was 149, of which 79 were RNs and 70 were LVNs. In addition, the facility reported that positions were converted to LVN III positions; all were currently posted. The Nursing Department had completed a data analysis of its nursing vacancies and staffing levels, which showed, month by month, the overtime and use of agency nurses in order to maintain their set minimum staffing rations. Given that more than one-fourth of the facility's population was rated as high risk for aspiration (because they had an enteral tube) one would expect nursing care hours to be higher for those who received their fluids, nutrition, and medications enterally. Further, they required observations/treatments associated with their eternal stoma sites. However, the facility staffing analysis did not include an acuity-based factor, which can be an important variable for the Nursing Department to ensure the individuals' complexity of care drive staffing plans. The facility should support the CNE with accessible/available resources to develop, and implement, an acuity system that incorporates acuity in the staffing mix. The monitoring team will follow-up at the next visits for steps taken by the facility address clinical acuity. The Nursing Department data reported, for the past six months, the following changes: • Conversion of the RN Recruitment Nurse position to RN Employee Health/Immunization Nurse, 8/1/13 • Conversion of three vacant positions to LVNs • Functions of Nurse Recruitment/Retention were transferred to Nursing Leadership staff • Resignation of the RN Hospital Liaison Nurse 8/23/13 and hiring of a new RN Hospital Liaison Nurse, 9/16/13 • 32 nursing hires • 31 nursing terminations, of which 11 (35%) were due to non-clinical performance issues	Noncompliance

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		• Resignations of 16 nurses. The facility determined that 7 (44%) were due to job demands or scheduling. Of the 16, three were RNs and 13 were LVNs. The CNE had developed and implemented a survey entitled "What Matters," which interestingly, targeted only the direct care nurses to address problems associated with staffing. The survey results included a number of responses, of which the three highest responses were job demands, schedule, and pay. During an interview by the monitoring team, the CNE reported that, as a result of the survey, she was holding meetings with the nursing staff toward their concerns, by beginning to assess and evaluate scheduling patterns. The monitoring team will follow-up at the next visit with the CNE regarding action plans as a result of the survey. In addition to these steps, the Nursing Department continued with their ongoing reward systems of retention activities that included recognizing individual nurses for performance. <u>Availability of Pertinent Medical Records</u> • Nursing IPNs were consistently written in SOAP format • Legibility of the nurses' handwriting had improved, however, the Nursing signatures and titles continued to be illegible • Late entries were not consistently documented in the IPN correctly • Entries in the IPN were carried over to the next page, and did not include the time • There were incomplete/blanks on many Plans of Care. For example, Individual #106 had a MCP that was blank for dates and signatures The facility's overall average of non-clinical documentation from July 2013 through November 2013 was 77%, an improvement when compared to the previous report's 66%. The Nursing Department reported that non-clinical documentation, such as legibility, writing in margins, inappropriate corrections, and appropriate late entries, have been added to each of their audit tools. The monitoring team will review, at the next, visit how the audit scores were impacted by the inclusion of the non-clinical documentation. <u>Hospitalization and Hospital Liaison Activities</u> The monitoring team conducted a brief interview with the Hospital Liaison due to scheduling conflicts for hospital visits. The Hospital Liaison Nurse reported the necessity to be present at the hospital during various times of the day, with a great deal of early morning hours spent at the hospital, in order to have direct communication with the physicians during their hospital rounds. The Hospital Liaison Nurse had recently transitioned to LSSLC on 9/16/13. Previously, she functioned as an RN Certified Case Manager (CCM) at the hospital. The Hospital Liaison Nurse completed orientation and begin visiting hospitals on 10/15/13. During the time the position was being filled, the CNE made staffing assignments to ensure there was not a lapse in Hospital Liaison visits.	

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		The Hospital Liaison activities included: • Conducting onsite hospital visits • Completion and distribution of Hospital Liaison reports to CNE, physicians, ADOP, RN Nurse Case Manager, Nurse Managers, PNMT Nurse, and IDT team members • Coordination of discharge planning with IDT's, PNMT Nurse, RN Case Manager, Infection Control Nurse, and Infirmary Nurse Manager • Entry of hospital transfer data into the facility's AVATAR system • Maintaining a data base of hospital/ER visits, dates of admission/discharge and discharge diagnosis • Conducting Nursing Audits Reports from the visits were read each morning by the CNE or designee at the Morning Clinical Meeting, and questions or concerns were conveyed back through the CNE to the Hospital Liaison. As the Hospital Liaison continues to establish a relationship with the hospitals, and establish a hospital routine, the monitoring team anticipates that the Hospital Liaison will have opportunities to directly bring the information herself to the Morning Clinical Meeting, so that there is a more direct opportunity to exchange information, and to become more integrated with the team. Since the last monitoring team visit, the facility reported some roadblocks to gaining remote access to "real time" records with outside tertiary care facilities, but planned to continue to work toward this goal. From the period of 1/12/14 through 1/17/14 the monitoring team reviewed 13 of the most recent and current Hospital Liaison Reports and IPNs for Individual #361, Individual #85, and Individual #22 and found: • Eleven of 13 (84%) Hospital Liaison Reports contained sufficient information to inform the teams about the health status of the individual • Thirteen of 13 (100%) contained pertinent information on laboratory tests and the results • Thirteen of 13 (100%) contained information that the individual's PNMP was provided to the hospital and was being utilized The monitoring team was impressed that visits occurred daily (although not required by policy) and found: • Synopsis of the individual's overall health status and response to treatments and medications completed for each day of the hospitalization. • Documentation of the Hospital Liaison interactions with the DSP as to the status of the individual.	

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		• Actions taken by the Hospital Liaison Nurse as a result of face-to-face observations of the hospitalized individual. For example, her assessment of Individual #361 noted that her abdomen was "very hard and distended." She discussed with the hospital nurse, the individual's output status. The Hospital Liaison Nurse also gave instructions to the DSP, further ensuring the DSP understood the importance of observing and reporting the individual's output or lack of output to the hospital nurse. • Notwithstanding the positives, the monitoring team did not locate within the IPNs or Hospital Liaison Reports, documentation of discharge planning activities. For example documentation of ISPAs planned, held, and attendance in the IPN notes by the Hospital Liaison Nurse or designee. For instance, Individual #85, who's post hospital discharge case warranted contact isolation, use of medical restraints (hand mittens), and physician recommendations for continuity of the individual's treatment planning activities, should have included an IPN note by the Hospital Liaison Nurse. Transfer/Post Hospital ER/LTAC Nursing Assessments The monitoring team reviewed Transfer/Post Hospital ER/LTAC Nursing Assessment for Individual #413, Individual #383, and Individual #120, who's records documented more than one transfer and associated ER/LTAC Nursing Assessment) and found: • Five of five (100%) transfer forms included the reason for the transfer • Five of five (100%) transfer forms included documentation of records of applicable records to be sent to the ER/Hospital with the individual • Five of five (100%) transfers included documentation communication between the facility and hospital RN Compliance to the effectiveness of the Post Hospital ER/LTAC Nursing Assessments could not be evaluated by the monitoring team due incomplete records. Assessment and Documentation of Individuals with Acute Changes in Status The monitoring team attended three of the Clinical Morning meetings held during the week of 1/13/14 through 1/17/14. The meetings were well attended by relevant staff where section leads or designees provided reports on the status of individuals having planned medical appointments/procedures, restraints, acute changes in health status, hospitalizations, and infirmary admissions/discharges. Reports were read by each section. For example, Nursing provided up to date information from the Hospital Visits. The monitoring team was provided an outline agenda for each meeting. Also for each meeting, the Infirmary Nurse Manager provided a document that included Infirmary Daily Census, discharges, ER Visits, Hospital Admissions, and ER/hospital visits not resulting in an Infirmary Admission. The monitoring team reviewed the meeting notes of the last five	

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		Clinical Services Morning meeting reports dated 1/1/14 through 1/9/14. The meeting notes were organized by section and included a summary regarding the individual's health status. The meeting notes also contained a categorized documentation table for tracking the status of the recommendations. In addition to attending the meetings, the monitoring team reviewed the records of two individuals who had acute changes that resulted in a hospitalizations and found: • On 12/27/13 at 8:55 pm, Individual #361's record documentation of the DSP reporting a vomiting event to the nurse. The documented date was in error. The date in the record corresponding to the physician order was 12/26/13. The IPN nursing note documented that the feeding was stopped and that there was physician notification. The IPN nursing entry indicated that the individual's Scopolamine Patch for vomiting was also present and intact. The nurse documented the administration of rectal Phenergan in the nursing IPN. The IPN nursing note had an omission of documentation of reporting to the physician any indications that the individual currently had in place a medication to prevent nausea/vomiting prior to proceeding with administering a second PRN medication. The monitoring team also found the record problematic for: o Omission of a review of historical data of intake and output, elimination records (initial nursing IPN assessment of the vomiting) o Omission of a Hemoccult test (a test for measuring the presence of blood) o Documentation of reporting by the nurse to the physician for the change in color of emesis, from vomitus occurring on 12/27/13 at 9:45 am. o The December Medication Administration Record and Enteral Feeding record were not made available in the record. The individual's IHCP associated with the 5/13 ISP did not include interventions for administration of prescribed prn medications for vomiting, although the medications were ordered in March 2013 and April 2013, and were reflected on the MAR as ongoing orders. o On 1/1/14 at 1:10 pm, the individual experienced an episodic event of vomiting. The IPN nursing entry noted the individual had in place her PRN medication for vomiting, a Scopolamine Patch. The nurse administered a second medication for vomiting and documented that the individual had received a third PRN medication, a breathing treatment. The record did not contain information prior to the breathing treatment that the abnormal lung sounds (wet lungs) were called to the attention of the physician. Only when the individual had increased respiratory distress was the physician notified by the nurse. Orders were received to place on oxygen and transported via 911 to the emergency room where she was subsequently admitted to the hospital. The individual was discharged on 1/14/14 with a diagnosis of bacterial pneumonia, facility	

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		acquired. The monitoring team expresses that at any time when an individual has two or more drugs to treat the same symptoms (e.g., vomiting, associated with an acute episodic event), one would expect a reasonably prudent nurse to call and review with the physician prior to administration. • On 10/29/13 at 9:45 am, Individual #174's nursing IPN note indicated notification that the individual had vomited. The nursing assessment included vital signs, documented that the feeding was stopped, and described the emesis as to amount, color (tan), and odor. The monitoring team was unable to locate a physician's order to hold the feeding for an hour. The IPN note did not include a review of elimination records, or review of trigger sheets. On 10/29/13 at 1:00 pm, the individual had two additional episodes of vomiting. The nursing IPNs had an omission for notification to the physician, and omission of Hemoccult testing. Thus, the nursing protocols were not followed. The IHCP contained interventions from the nursing protocols, which included actions steps (i.e., following the nursing vomiting protocols), but were not followed. The IPN nursing notes for individuals with acute changes in their health care status were not consistently documented when their problems were resolved, and/or the effectiveness of the interventions/treatments provided. The Nursing Department should ensure nurses are sufficiently trained in the application nursing assessment/physical assessment/nursing protocols, that there is integration of critical thinking when individuals experience a change in their health care status, and that the requirements in the various protocols are adhered to for reporting to the individual's primary care provider (physician, nurse practitioner, physician's assistant). <u>Infection Control Preventionist Activities</u> The Infection Control Preventionist (ICP) continued to maintain responsibilities of two additional roles and functions. Recently, the responsibilities associated with Immunizations/Employee Health, however, were re-assigned. The ICP, having been in the position for nine months and having no formal Infection Control Training prior to the position, should also be relieved of the Wound Clinic responsibilities, so that the role is solely devoted to the facility Infection Prevention Program to addresses detection, prevention, and control of infections among the individuals who live at LSSLC. The ICP was credited with beginning and tracking the timeline of the flu outbreak, consulting with the state/local health department public health nurses, and fostering communication with the facility physicians to keep abreast of recommendations by the local health department. Recommendations included treatment with Tamiflu. At the time of the monitoring visit, several homes were under contact isolation.	

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		Activities for this monitoring period by the ICP included: • Training/Inservice Self-Improvement Infection Control Courses • Completed last six months of Antibiograms • Conducted NEO Infection Control Training • Provided educational materials and in services for Flu, Immunization, Scabies, Conjunctivitis • Consulted with External Facilities, State/Local Health Departments for outbreaks of Flu • Implemented Isolation/Contact Precautions for MDROs, Flu • Conducted six of six Infection Control Meetings • Conducted weekly Wound Clinics • Outbreak Investigations Flu, Scabies • Provided Health Alert information for Cyclospora (intestinal illness caused by a microscopic parasite, associated with eating fresh fruit) Outbreak in Texas <u>Infection Control Meetings</u> The monitoring team attended the combined Infection Control Meeting Committee held on 1/14/14. The ICP chaired the committee. The meeting included a review of the December 2013 minutes and actions taken. A large amount of the meeting time included discussions regarding storage boxes, or the lack of. The Chair should have curtailed the discussion and enlisted a subcommittee to look into the issue and bring recommendations from the subcommittee back to the Infection Control Meeting. The minutes included the facility establishing standardized surveillance guidelines for reporting infections. The monitoring team reviewed the infection control data for the last six months and found: • UTI infections declined by 50%, but more work is needed to continue to investigate the underlying reason for new and/or recurring urinary tract infections. UTI infection data did not include whether or not the infection was with or without an indwelling catheter. • Eye, ear, and skin infections were not significantly decreased, and in December 2013, ear and skin infections were increased by 50%. • The facility continued to document a high number of non-respiratory infections occurring during the flu outbreak. Although the facility's hand hygiene data documented a high percentage of compliance, the monitoring team, on the many observations made during the week, did not find support for these data. The monitoring team often witnessed nurses with stethoscopes taken from around their necks, conduct an assessment and placed it back around their neck, without disinfecting the stethoscope, while going from individual to individual. Much more work	

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		is needed to provide education to all staff regarding hand hygiene and Standard Precautions. The facility should invest in tools that help staff see their results of their own hand washing, and exposure of high touch area, in the prevention of transmission of infections. The monitoring team reviewed two individuals with recent infections. • On 12/25/13 at 7:00 pm, Individual #361's IPN reported that the individual had a change in her skin condition and was referred the next morning to the medical clinic. The individual was seen by the physician and a diagnosis of "skin rash? VZV" (Varicella Zoster Virus, (Shingles)). Because the individual was suspect for VZV, and on 12/28/13 was diagnosed with VZV. The record was problematic for: o Omission of notification to the Infection Control Preventionist o Omission of an availed an Acute Care Plan for the VZV o Omission of an availed staff instructions/staff signatures sheet that would have accompanied the absent Acute Care Plan o Omission of documentation regarding the institution of isolation precautions • On 10/26/13 8:23 am, Individual #413's IPN reported that the individual was being sent to the emergency room for possible shingles. There, he was diagnosed with Herpes Zoster (Shingles) right face/trigeminal area, and subsequently admitted to the hospital. The IPN did not include notification to the ICP on 10/26/13 of the positive diagnosis for Shingles. The individual was discharged on 11/1/13, where the IPN documented to institute isolation procedures. The record did not include an ACP. The monitoring team stresses the importance that any time infectious disease or the signs and symptoms are suspect, the ICP should be notified, so that necessary preventive measures can be put in place promptly. The ICP should ensure that staff are familiar with her role in the prevention of infections, and have been instructed to contact the ICP when infections are an infectious process is suspect. Surveillance is one of the primary roles and functions of the ICP position. The facility should ensure, through new employee orientation, and ongoing inservices, that staff know what they are to report to whom they are report, and that they have full accessibility to the ICP. <u>Skin Integrity/Wound Clinic</u> The Skin/Integrity Meeting followed the Infection Control Meeting and was chaired by the ICP. The meeting did not include an agenda. The meeting included a review of the facility pressure wounds and skin integrity issues. The facility tracks their pressure wounds as to whether or not they are facility- or community- (hospital) acquired. The facility had not been successful, since June 2013, to obtain an acceptable zero rate for its decubitus ulcers. Currently, the facility had three, of which two were reported as hospital-acquired. The	

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		CNE should collaborate with the Hospital Nursing Director to ensure there is ongoing communication when individuals are admitted from the facility with decubiti, and when individuals are admitted to the facility with decubiti, for strategies to eliminate care issues associated with the decubiti. The facility should undertake a process to evaluate care issues associated with decubiti that occur at LSSLC. The facility also continued to maintain elevated numbers with soft skin infections. The facility should investigate the underlying reason for the trends occurring in units. The monitoring team, on 1/15/14, attended the wound clinic rounds with the CNE in attendance. The Wound Clinic Team included the ICP, Physical Therapists, and a member from the Hab Team. The Wound Clinic Team rounds included assessments, removing of dressings, application of treatments, and documenting the care. The monitoring team reviewed Individual #241's "Wound Care Clinic" IPNs from 11/1/15 through 1/15/14 and found: • Wound clinic visit were held weekly, except when the individual was hospitalized. • Nine of nine (100%) described the size, length of the wound. • One of nine (11%) addressed if there was any depth to the wound. • One of nine (11%) included documentation of preventive aids or positioning plans. • Nine of nine (100%) were staged using the PUSH system. The ICP implemented, on 1/15/14, an IPN formatted note that was a more inclusive and more consistent method for describing the wound, including the depth. The format also included information related to an associated infection of the site, and whether or not precautions were initiated, if a nursing care plan was in place to prevent wound infection, and if the individual was taking an antibiotic. The IPN note had, for this wound, an initial diagnosis date of 11/6/13, and noted to be hospital-acquired. The 1/15/14 IPN note by the ICP documented that an ACP was in place. The ACP or staff instructions were not made available in requested documents, even though the 1/15/14 wound clinic indicated one was present. In addition to the above, the monitoring team found the wound clinic problematic for: • Infection control practices. For example, during the observation of one of the individuals, the same scissors used to remove a bandage from one foot, was used on a second foot, for another individual, and the camera cord dangled over/near the wound while trying to capture a picture of the wound. • Inadequate lighting was available in order to adequately visualize the wound. For example, for one individual, the lighting was so poor, the monitoring team requested the Wound Team use a flashlight in order for the Wound team to	

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		adequately visualize the wound. • Omission for having a copy or current record present during the review for the current treatment orders for the individuals. • IPNs reportedly were written at the end of the clinic, as opposed to committing to writing the IPN at completion of each individual's care. • The Wound Cart that was used to hold supplies was taken from place to place; the handle had been wrapped with tape and was dirty. • A garbage bag for dressings was tied and untied and taken from unit to unit, for disposing of soiled dressings. A plan should be put in place to ensure that these unacceptable infection control practices do not continue. The monitoring team strongly recommends, especially due to the number of individuals who had decubitus as a result of their care/lack of care, and due to the number of individuals with stomas with device-associated procedures (e.g., feeding tube, ileostomy, Foley catheters), that the facility consider a certified RN Wound Enteral Stoma Nurse as a member of the nursing team. On a positive note, the facility held a vendor supported inservice training on Skin and Wound Care that was attended by the monitoring team. The inservice was well attended by the incoming and outgoing first and second shift of nursing staff. The monitoring team's document request included a document entitled LSSLC Wound and Skin Care Guidelines. It included the MEDLINE Logo and MEDLINE products that should be used. The document also referred to treat wounds according to protocols, of which unfortunately the monitoring team did not locate in the document requests. In addition, no supporting information was found that the Guideline had been reviewed in collaboration with, and was approved by, the physicians because the products contained a drug that would for administration/application, require a physician's order. <u>Immunizations/Employee Health</u> The monitoring team was impressed that the recently assigned Immunization/Employee Health Nurse had conducted a review of all the individuals' current immunization status, of which the data were presented in graph form. The data concluded an overall 98% of immunizations. In addition to the graphs, the data provided a 1/12/14 update for the percentages less than 100%, of which consents had been sent out in December 2013, and the facility was awaiting a response from the family member/guardian. The monitoring team will follow-up at the next visit regarding the status of those consents. The Immunization/Employee Health nurse reported an overall 84% of staff who had received their flu vaccination, of which the facility is commended for its positive campaign efforts. The remaining percentage included refusals, but did not include the reason why	

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		the vaccination was declined by staff. Individuals who are symptomatic or diagnosed with flu are sent home and returned to work once their physician determined non-communicability. As the Immunization/Employee Health Nurse was new and as the roles and functions were evolving, the monitoring team will follow-up at the next visit to review activities and trainings. <u>Infirmary</u> The monitoring team reviewed documentation of all individuals admitted to the Infirmary from 6/3/13 through 11/29/13. There were 230 admissions for an average daily census of eight. The Infirmary continued its admission practices for: • Individuals who had been discharged from the hospital. • Individuals who required nursing interventions more than every two hours. • Individuals who needed a dedicated bed and bathroom to isolate their infections. • Individuals who were transferred from their home unit as a result of an acute change in their health/mental health status. • Individuals who will be having a special procedure. • Individuals who had received dental procedures. • Individuals returning from the Emergency Room. The infirmary staffing remained consistent, and continued as a unit to maintain a higher nurse to individual ratio. The total number of direct care nurses RNs was 10. The facility should develop guidelines for admissions, discharges, and transfers. The facility should also examine its own data as to lengthy infirmary stays, hospital discharges, and emergency visits that resulted in a return to the hospital within 24 hours. <u>Emergency Response Activities /Emergent Event</u> The monitoring team, during the weeklong visit, made unannounced visits to all areas located on the campus that held emergency response equipment, for a total of 15 sites. Emergency equipment associated with those sites (suction machine, Automatic External Defibrillator (AEDs), and Oxygen) were proficiently demonstrated by the nursing staff located on the units. It was positive that the facility had acted on the monitoring team recommendation by adding emergency equipment to the large gymnasium, adjacent to the pool. The facility also revised the Medical Emergency Response and Drills policy to include the additional site on 12/17/13. The monitoring team will follow-up, at the next visit, on the status of the changes to the cards. The NOO is credited with assuring, during the week of the monitoring visit, that training was provided to staff where the equipment was located, how to perform regular checks, and how to document the checks. This was also evidenced by the Training/Roster sign in sheet dated 1/16/14. The facility was updating the "small plastic cards" carried about by all staff to include the new site.	

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		The monitoring team review of the Emergency Equipment used to respond to all drills on the Campus, by the Campus RNs, was problematic. The weight of the combined equipment (weighed on scales) was over 100 pounds that the nurse was expected to push, pull and lift across all terrains, and steps located on the campus when responding to an emergency. The CNE and the RN Infirmary Nurse Manager were present during assessment of the overly weighted equipment and agreed that actions should be taken to revisit the essential equipment requirements in consultation with expert outside resources, as suggested by the monitoring team. The monitoring team will follow-up at the next visit as to the status of the equipment. The monitoring team reviewed the AED Emergency Bag Check- off Sheets for 12/1/13 through 1/13/14 and found emergency equipment was consistently documented in accordance to facility policy. The facility's CTD reported queried on 12/31/13 documented the following classes for the total number of staff trained, and reported no data associated/delinquent for having been trained. • Basic Life Support for Health Care Provides, 100% trained. • CPR Basic, 100% trained. • Responding to Hazards and Emergencies, 100% trained. The facility reported for the period of 9/13 through 12/13, that a total of 133 Mock Drills were conducted, with an overall pass rate of 88%. The monitoring team reviewed the findings of the Emergency Drill Checklist used to conduct the Drills, and was concerned regarding findings from the reviews of the failure of nurses to attend the drill because of a shortage of nursing staff, nursing not responding to the drill, and nurse not responding due to not having a car and "not having any way to transport equipment." Examples were Emergency Drill Checklists dated 11/12/13, 11/18/13, 11/20/13, and 11/26/13. Because the drills were unannounced, and because staff were required by training to react/respond appropriately, with the assumption each drill was "real," the monitoring team was concerned about the rationales provided for not responding to the mock drills. A review of the Monthly Nurse Safety Meeting Agenda for the last six months found meetings were held as scheduled, and that relevant staff were in attendance, including representation from Risk Management. The minutes followed an agenda that included a review of Mock Emergency Drills, Emergency Drill Team, Emergency Equipment, and Nursing Safety/Health Issues. However, there was an omission for having a defined category for reviewing the number of actual emergencies that occurred, and for reviewing improvement changes to the emergency response systems.	

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		Individual #106: On 10/2/13 at 10:10 am, the Nursing IPN late entry note indicated the individual was being taken from the dining room to his home, when the DSP requested she needed help because the individual was choking. The IPN nursing note reported that the individual was removed from his wheelchair in order to perform the Heimlich maneuver, which was attempted several times. The individual became unresponsive. The Medical IPN indicated the facility emergency response protocol was initiated, which included an alert notification to 911. The individual was transferred to the ER and later returned to the facility Infirmary. The record contained a completed Post Hospital/ER/LTAC completed Nursing assessment. The nursing IPN notes were followed to resolution regarding the emergent event dated 10/6/13 at (time not legible). The individuals COS IRRF, dated 8/19/13, indicated he was high risk for choking. Although the COS IHCP goal documented was inadequate for his Risk, the IHCP action steps included appropriate short- and long-term monitoring plans that included integration of other health disciplines, and signs and symptoms the DSP should observe, document, and report. Overall, this was a positive example of the effectiveness of the emergency response system training. <u>Quality Enhancement Efforts</u> Since the last monitoring visit, the facility implemented a process on 7/20/13, entitled "Weekly Challenge," which included written nursing scenarios for health problems, questions about the health condition/presenting problem, and how the nurse would direct care and interventions for the individual, including whether or not to initiate a call to the physician based on the problem, and based on their assessment. The Weekly Challenge was made available to all nurses via the computer for their response to the questions. The monitoring team reviewed all of the samples provided in the presentation book and found that responses for the different problems were not consistent, such as for when to call the physician, the assessment or lack or assessment/interventions, and implementation of protocols. All of this was similar to the monitoring team findings found in the records. The monitoring team met with the QA Nurse on 1/16/14. The QA department recently filled the second RN position with a nurse from the facility. Due to the fact the department only had one nurse, there was little activity between QA and Nursing to meet on a frequent basis to establish QA process, such as inter-rater agreement. The QA nurse continued to complete the facility Mortality Summaries. The monitoring team reviewed the recommendations for nurses and found the recommendations were addressed in accordance in the facility policies timelines, as appropriate to the local facility. See section L of this report for information on Mortality reviews.	

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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 parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample) for this subsection because the facility had made limited progress. The noncompliance findings from the last review stands. <u>New/Revised Policies, Procedures, Protocols</u> There was one policy: o SSLC Comprehensive Nursing Assessment Review/Quarterly Nursing Record Review/Quarterly Physical Assessment Guidelines, 9/13 Based on the documents submitted for training, the monitoring team was not able to discern the completion dates and percentage of nursing staffing who had completed the training for this policy. <u>Nursing Assessments</u> The monitoring team reviewed a sample of eight records containing completed Admission, Annual Comprehensive Nursing Assessments, and Quarterly Nursing Record Review/Quarterly Physical Assessment. These were selected from the facility's At Risk List for individuals' identified at high risk health conditions, from each of the units for Individual #27, Individual #203, Individual #361, Individual #241, Individual #106, Individual #591, Individual #120, and Individual #413. • Eight of 12 (66%) recently completed Admission, Annual, and/or Quarterly Nursing Assessments were available for offsite review. Others were not useable for the review, when a page was missing, or a physical assessment was missing. • Eight complete records sets (100%) of the Annual/and/or Quarterly Nursing Assessments were completed timely, in accordance with the facility policy. There was improvement completing the assessments timely, compared to the last review. For the eight complete record sets, Nursing Assessments were reviewed using a monitoring tool comparable to the tool used by the facility that included the requirements in the revised Guidelines. The monitoring team found an overall 78% rating for Nursing Assessments/Quarterly, which fell below the expected criteria of 90%. Critical items that fell below 90% included: • Current active medical diagnosis were not consistently updated and lacked consistency between the current active medical problems listed on the assessments • Immunization data status were incomplete and had omission of the current status of the immunizations, as well as summary analysis of the relevant data • Complete documentation of the baseline vital signs and oxygen saturation SP02 were not consistently documented on standardized forms	Noncompliance

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		• Assessment summaries failed to qualify for every problem/diagnosis by indicating whether or not progress was made toward the stated goals and/or the effectiveness of the care plans. The facility for the next six months should focus on the a systems approach that includes mentoring by the newly designated RN Case Manager Supervisors Assistant, that includes over-the-shoulder reviews, and face-to-face documentation reviews for each of the nursing assessments to ensure consistency of the quality of the nursing assessments.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample) for this subsection because the facility had made limited progress. The noncompliance findings from the last review stands. The monitoring team interviewed the RN Case Manager Supervisor, with the CNE in attendance. The RN Case Manager Supervisor had 23 RN Case Managers. Over the last six months, two vacancies occurred, of which the positions were currently filled. The RN Case Managers' caseload in the home requiring intensive medical care varied from 13 to 16 individuals for each case manager. For homes with individuals requiring intensive/complex behavioral needs, caseload varied from 18 to 21 individuals. As reported by the RN Case Manager Supervisor, caseload was based on a numerical assignment as opposed to the application of acuity to the case mix. The RN Case Manager Supervisor recently redistributed the caseload to cover the vacancies. Therefore, the caseloads were increased at the time of this visit. The caseloads will be re-adjusted upon the new RN Case Managers completing orientation. The RN Case Manager Supervisor also established an RN Case Manager Assistant in order to ensure consistency with the Comprehensive Nursing Assessments, Integrated Health Care Plans, and Risk Processes. The RN Case Manager Supervisor reported that, as the position evolves, she was consistently making changes to the role and function of the position. The monitoring team will follow-up at the next visit, regarding the structuring of the RN Case Manager Assistant, and goals obtained as a result of the position. <u>Nursing Discharge Summaries</u> The monitoring team reviewed five Nursing Discharge Summaries and accompanying Discharge Packets for Individual #412, Individual #226, Individual #505, Individual #23, and Individual #138, all recently discharged to community living. The findings included: • Five of five (100%) Nursing Discharge Summaries were completed prior to the individual's discharge/transition to the community. • One of four (25%) Nursing Discharge Packets were complete for each individual, containing the IRRF, IHCP, Immunization Record, Current Medication Record, last MOSES/DISCUS, and Nursing Care Plans/Staff Instruction Sheets.	Noncompliance

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		• Three of five (60%) sufficiently addressed the individual's preferences, special behaviors, and how the individual expressed pain. • None of the five Nursing Discharge Summaries contained the individual's PMNP, even though three of the individuals had medium risk ratings for choking. • One of one (100%) was at high risk for aspiration of which the IHCP and DSP instructions were scant and did not contain substantive information to ensure the health problems would be sufficiently monitored and/or reported. For example, the individual received his feeding enterally, however there was no mention he received his nutrition/fluids/medications enterally in the DSP instructions. • None of the records containing an IHCP and associated DSP instructions were written in easily understandable terms that could be understood. The Nursing Discharge Summaries completed by the RN Case Managers varied from unit to unit. Nursing Discharge Summaries are powerful documents that can be used to ensure continuity for supports for the individual transitioning to the community. The monitoring team suggests the State Nursing Coordinator develop uniform processes, in other words, instructions for the Discharge Summaries. For individuals requiring nursing procedures, ensure the summary documents, as applicable, how facility RN to community RN communication and/or training occurred. The CNE provided the monitoring team with communication from the state office Nursing Coordinator, dated 11/18/13, of the revised Acute Care Plan template. The CNE and NOO also referred to a "bank of interventions" from which the nurses could choose when completing the ACP template. The CNE and NOO also produced a tool for monitoring the ACP. The monitoring team will follow-up, at the next visit, the effectiveness of the new process. The monitoring team reviewed a sample of five individuals (Individual #383, Individual #27, Individual #591, Individual #120, and Individual #413) who had recent or current infections for individuals and found: • Five of five (100%) did not sufficiently include how the individual would participate in his or her care in preventing the spread of infection. • Three of five (60%) contained sufficient baseline data to identify the infection that lead up to the implementation of the care plan. • None of the five plans included staff instructions that could be easily understood. • Three of five (60%) plans included relevant preventive measures. • Three of five (60%) plans included the frequency of the interventions. • One of five (20%) sufficiently incorporated the nursing protocols. • None of the five with antibiotic therapy included notification to the Infection Control Preventionist (ICP).	

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		In addition to the findings above, the ACP were problematic for: • ACPs for the current/ongoing problem had one or more care plans for the same problem that failed to include the date the problem was resolved. Thus, making it difficult to discern which plan should be followed. • ACPs contained different title headers that had been marked through and overwritten with another title. For example, Individual #591 had two plans, one entitled Medical Care Plan, which was struck through, an Acute Care Plan, and a separate one entitled Abscess. • ACPs that contained revisions were difficult to follow, due to the number of handwritten changes, stricken changes, arrows drawn, and illegibly of the revisions located on the plan (e.g., ACPs for Individual #591). • ACPs for individuals with infections often did not include sufficient signs and symptoms the DSP should report. For example, Individual #591's plan did not include instructions for reporting the color, amount of drainage, or an odor for the infected site. The quality and completeness of the ACPs showed little improvement; much work is needed here. The Nursing Department should provide over-the-shoulder monitoring in the implementation of health care plans to ensure consistency among the plans, and that the plans accurately reflect the individuals' problems/diagnoses. The plans should be individualized for the individual.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	<u>Inservice on New/Revised/Reviewed Policies, Procedures, Protocols, and Guidelines</u> • 8/13 Physical Nutritional Management Policy, 100% of the nurses were inserviced. • 10/13 Neurological Assessment Update and Follow-up Procedures, 100% of the nurses were inserviced. • 11/13 Community Outings Policy, 99% nurses inserviced. • 11/13 Out of Hospital DNR, 100% nurses inserviced. • 11/13 Death of a Resident Policy, 100% nurses inserviced. • 10/13 Antibiotic Initial Dose Times, 96% nurses inserviced. • 11/13 Common Elements of Care, 100% nurses inserviced. • 11/13 Injury Reporting, 97% nurses inserviced. • 12/13 Injuries to Individuals, 92% nurses inserviced. • 1/14 Pre-Sedation Consultation, 100% nurses inserviced • 11/13 Planning Care: Minimum Elements of Acute Care Plans (incorporated into Nursing New Orientation).	Noncompliance

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		Training/Education The monitoring team interviewed the Nurse Educators, in the presence of the CNE on 1/14/14. The Nurse Educator reported that she maintained data for each training on each individual nurse in a spreadsheet, of which she reported hand counts when asked to make determinations of the number of nurses trained on assorted subjects. The monitoring team discussed with the CNE and Nurse Educator the necessity of being able, at any time, to have an ongoing tabulation of the nurses trained or inserviced. The CNE notified the NOO who, and to her credit, tabulated the spreadsheets to provide the monitoring team with a document of the current number of nurses trained. The Nurse Educator reported, when training, she applied several methods of teaching to ensure inclusion of all learner types. The Nurse Educator provided information that new policy or procedural changes were incorporated into the orientation for new hires. Reportedly, new policies were sent out from the office of the CNE to Nurse Managers. The Nurse Managers held inservice or nursing meetings to ensure staff were inserviced on new/revised policies, procedures, protocols. The Nursing Department maintained nursing rosters and a spreadsheet with the up to date number of nurses inserviced. Nurse Manager's followed-up with their nursing staff to re-schedule any missed inservices or training. The Nurse Educator also reported that she did go out on the units, making rounds and querying nurses on the use of protocol cards. The Nurse Educator reported that, at the present time, she did not have any supporting documents of the outcomes from those queries. The Nurse Educators provided remedial training, as requested. The Nurse Educators reported that training was provided on all shifts at different times to ensure staffing was not disrupted. Since the last visit, the Nurse Educators had acquired a large training room and received ATV equipment for conducting training. The monitoring team had an opportunity to visit the training room, which was a well organized, quiet space that appeared to be conducive to learning. Poster boards were located on the walls as learning prompts for the different protocol cards. There was a training station, complete with emergency response equipment, to simulate an emergency. Nonetheless, the facility lacked the appropriate mannequins for return demonstration/check off. For example, auscultation of the different types of normal and abnormal heart and sounds. The facility should invest in obtaining the necessary training tools in order to ensure the adequacy of physical assessment skills. Nursing Education Activities with Other Disciplines The Nurse Educators reported the following coordinated training activities occurring as part of NEO through CDT that included other disciplines (e.g., DSPs, CMAs) • Seizure Safety and Vagal Nerve Stimulator • Preventing Aspiration and Aspiration Trigger Data Sheet	

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		• Falls Protocol • Observation and Reporting Clinical Indicators • Bowel Management • CPR BLS (nurses) • Recreation CMA Annual Training <u>Training</u> The following is a list of trainings for the past six months and the percentage of nurses trained. • Medication Administration Training, 100% of nurses trained. • Mosby's Class (Heart) 4th Quarter, 100% of nurses trained. • Mosby's Class (Head and Neck) 5th Quarter, 93% of nurses trained. • Annual Skills Fair 21 Competences, 100% of nurses trained. • Physical Assessment Class, 100% of nurses trained. • SOAP Documentation Class, 100% of nurses trained. The monitoring team reviewed the document submission of nursing rosters, spreadsheets, and nursing education calendars and compared the names to the spreadsheets submitted for training. The monitoring team also reviewed the outline for the NEO for nurses, which provided inclusion of the 23 Protocol Cards with the Mosby Classes and Physical Assessment Classes. The instruction models/curriculums specified by topic, Class Room Skills Check Off, and Competency Exam. The NEO topic included a number of emails as part of the training. The monitoring team suggests the incorporation of those items that are changes to policy/procedural/protocol be incorporated into the existing policy/procedure or protocol. The monitoring team, however, was not able to discern from the two summary tabulations submitted, that "all" nurses had received the mandatory trainings. For example, Mosby Course Class identified the 4th and 5th quarter in the received document request summary for percentage of Nurses Trained 6/1/13 through 12/10/13 . <u>Implementation of Nursing Protocol Cards</u> Individual #354: On 1/7/14 at 7:50 a.m., the med nurse reported to the RN that while staff were trying to take the individual's temperature, staff had to remove his helmet, and he head butted the door frame. The RN determined a head injury and initiated the Mild Head Injury Protocol. Vital signs included an abnormal finding of a heart rate of 59. The nurse assessed that the individual was alert, responsive, and "very combative." The nurse documented that the individual had no injury to his forehead though it was red, of which the DSP stated was normal when his helmet was on. The required Neuro Form for documenting the neuro status was not included in the documents reviewed by the monitoring team. The IPN also	

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		had an omission of implementing the Pain protocol. At 8:40 am, the DSP reported to the nurse that the individual had vomited. The nurse assessed the individual's vital signs and notified the physician of a heart rate of 48, who then gave orders to transport via EMS. An RN entry at 9:40 am documented that the med nurse reported the individual had vomited twice since neuro assessment started, and was concerned regarding his heart rate of 48. The RN finding was an abnormal neuro assessment. The nursing note did not indicate the exact time the physician was notified. The individual returned from the ER on 1/7/14 at 5:45 pm. An Acute Care Plan was not found for the head injury, even though the IPN notes indicated on 1/8/14 at 11:40 an ACP had been initiated. However, the monitoring team was unable to discern from the IPN nursing note, what problem was to be addressed on the ACP. Individual #241: On 11/12/13 at 2:20 am, the DSP reported that the individual was breathing funny. The nurse documented in the IPN that upon entering the room, wheezing was noted, respirations rate was 20, slightly labored, oxygen saturation of 96%, and temperature of 99.4. The nurse documented assessing the individual's lung sounds and documented "lungs with slight wheezing." The IPN plan included interventions to initiate respiratory protocol and provided instructions to the DSP. On 11/12/13 at 3:10 am, the IPN note included an assessment of the individual's vital signs, and documented Temp 99.8, respirations were 18 even, and "un-labored, no wheezing at this time." On 11/12/13 (no time documented) the nurse assessed the individual's vital signs. The temperature was recorded at 99.4 temporal, respirations 18, even but labored, and lung sounds wheezing from left and right upper lobes and strider from right lower lobe. The individual's oxygen saturation was measured at 93%. The assessment was for an "expiatory wheeze, mild temp." The plan included placing on sick call, monitor breathing and temperature every four hours, and place on temperature protocol. On 11/12/13 at 1:00 pm, a nursing entry documented administration of Flu vaccine, temperature 97.8. On 11/12/13 at 1:30 pm, the IPN documented an RN to RN report of possible influenza, low grade temperature with cough. The nursing plan included the telephone orders noted on the physician order form dated 11/12/13 at 11:25 am. The orders included an injection of an antibiotic to be administered STAT, Tamiflu, oral antibiotic, medication for wheezing/congestion, admission to the infirmary, and vital sign monitoring to include neuro checks every two hours overnight, and lab work with a screening for Flu. At 11/12/13 a verbal order included discontinuing the Zithromax. Two Nursing IPN entries followed documenting "see neuro check sheet for details." The Neuro Check sheets were not in the record. In accordance with the Nursing Protocol for Respiratory Distress/Aspiration interventions for notification of the PCP for oxygen saturations less than 95% were not followed. Moreover, the IPN nursing notes of abnormal findings of labored respirations with strider, should have prompted a reasonably prudent nurse to notify the physician, as opposed to placing the individual on sick call. The monitoring team was concerned that the flu	

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		vaccine was administered without reviewing the Vaccine Guidance as to whether or not to administer Flu vaccine when someone had a fever or respiratory symptoms, and should have prompted the nurse to call the physician to question whether to administer the vaccine. The IPN had an omission of the date and time a physician entry of being seen in sick call or examined. The record contained a Medical Care Plan (MCP) for Influenza, signed by nursing and medical for requiring 24 hour nursing services. The Direct Care Staff instructions included in the record had omissions for preventing the spread of possible flu, other than a generalized statement regarding hand washing. The record did not contain notification to the Infection Control Preventionist (ICP) for possible flu. The record provided a MCP for Influenza signed off by Nursing that was perplexing. The monitoring team reminded nursing that nursing interventions are independent of medical practice. Nursing care plans are derived from independent nursing interventions of which nurses are held accountable. A dependent intervention is one that are prescribed by a physician, usually as orders, of which the nurse is responsible for assessing the need for the order; and evaluating the effectiveness of the order. Individual #591: On 11/26/13 the DSP brought the individual to the med room stating the individual "fell on buttocks." The nursing IPN assessment included vital signs, observations of the affected area of the fall, and documented a "purple bruise two centimeters by two centimeters." The nursing IPN noted pain that was assessed using the Wong Baker Pain Scale, and reported no signs and symptoms of pain. The IPN note included instructions to the DSP for monitoring and reporting signs and symptoms related to the fall. The documentation did not include a numerical assignment from the pain scale, or a head to toe assessment as guided by the Fall Nursing Protocol, though the facility later reported that both had indeed occurred. The IPN note had omissions for follow-up related to the fall. The next available nursing IPN note was documented on 11/29/13 (no time recorded) for a different complaint/ problem. Below are the facility's reports of their combined overall monitoring results for protocols, assessments, and care plans for December 2012 through November 2013 (December data were not in the overall results). Facility Audit for Protocol Cards for January 2013 through October 2013	

Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sept.	Oct.	Nov.	Overall average
69%	72%	74%	73%	74%	77%	77%	80%	84%	84%	88%	85%	78%

Protocol Card	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sept.	Oct.	Nov.	Overall average
Antibiotics	37	66	89	55	88	81	81	77	82	100	D/C	75
Constipation	67	84	79	69	82	85	80	81	92	93	D/C	81

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Pain	[redacted]		64	61	75	54	81	86	83	88	88	76
Seizure			33	77	70	88	100	80	71	81	91	77
Vomiting	79	76	83	83	85	77	79	89	92	86	D/C	83
Respiratory	68	65	86	78	68	76	67	90	78	93	No data	77

In addition to the above findings, the facility initiated a tool for Primary Provider Contact due to findings that improvement was needed for documentation of PCP contact. The results for November 2013 showed 51% compliance, which was consistent with the findings of the monitoring team.

The facility self-rated substantial compliance for M4. The monitoring was not in agreement. The monitoring team reported, throughout the subsections of this report, the degree of omissions in the application of nursing assessments, application of protocol cards, and implementation of plans of care and, thus, concluded that training had not transferred into practice sufficiently to address the health status of the individuals. More time is needed for nurses to gain experience in the consistency of application of nursing assessment/physical assessment, use of the various protocols, and the requirements for reporting to the individual's primary care provider.

M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The parties agreed the monitoring team would conduct reduced monitoring (i.e., smaller sample) for this subsection because the facility had made limited progress. The noncompliance findings from the last review stands. The facility had received communication form the state office Nursing Coordinator in October 2013 regarding the implementation of the revised/standardized Comprehensive Review and Assessment Guidelines along with Audit Tools. In addition the facility initiated Integrated Health Care Plan Audit Tools in November 2013. The monitoring team will follow-up at the next visit as to the findings from those implemented tools. <u>Inservice Education/Training</u> The RN Case Managers received the following inservice trainings: • Nursing Assessment Recommendations, Integrated Risk Rating Form, and Integrated Health Care Plan (IHCP) 19 of 23 (83%), received inservice training • Care plans –Change of Status -IHCP 22 of 23 (96%), received inservice training In addition to the above training, the RN Case Manager Supervisor, in an interview, stated that the Case Managers had been given the following handouts, also provided to the monitoring team: • Preparing for an Annual IPS Meeting- Risk Discussion Case Manager Responsibilities, which outlined specific timelines for completing the	Noncompliance

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		Comprehensive Nursing Assessments, IRRF, IHCP, and Aspiration Pneumonia/Enteral Nutrition Data Sheets. • Nursing ISP Prep Meeting Guidelines, which provided a listing of required documents, and documents to review prior to the meeting. For example: Recurrent acute conditions with interventions and their efficacy. The monitoring team reviewed five individuals': (Individual #27, Individual #106, Individual #413, Individual #203, and Individual #241) Nursing Assessments, IRRFs, and IHCPs and found: • Five of eight (63%) risk assessments sufficiently provided information that helped develop a plan to address the risk ratings. • Five of five (100%) indicated the IHCP was implemented in accordance with the facility policy. However, it was difficult to discern from the documents the dates of the plans for all identified risks were implemented. . • Five of the eight (63%) IHCP s included preventive interventions to minimize all the risk ratings. • Five of Five (100%) IHCP's were deficient in quantity and quality for the plans' interventions. • None of the five IHCP s were written in terms that were easily understood for staff other than nurses who are required to report triggers (signs and symptoms) associated with risk. For example Individual #27's record indicated he had a tube. The IHCP included signs and symptoms for eating orally. The IHCP did not include if signs and symptoms occurred to ensure the individual was positioned in accordance with his or her PNMP plan regarding the risk of aspiration. The monitoring team attended the ISP meeting for Individual #551 and found: • Individual #551 was not in attendance at her own meeting and, therefore, did not participate in the ISP, due to contact precautions in place at her home due to an outbreak of the flu. There was no information found in the individual's record that any member of her IDT had discussions regarding alternatives or measures that could have been considered for the individual to attend her meeting. The monitor was also concerned that the individual's representative attending via phone was not aware before the meeting that she would not be attending. • All relevant IDT members attended the ISP/IRRF meeting. • The individual's record was present during the meeting for reference, and was utilized at different times during the meeting. • A lengthy discussion took place in determining the continuation/writing of a therapy goal for the individual. The team had different viewpoints regarding the continuation of an existing goal, even though there were documented functional assessments as to the lack of progress and the rationale for the lack of progress.	

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		• RN Case Manager, when questioned by the IDT about the individual's seizure activity, used the individual's record to provide the most current information regarding pertinent information about the individual's seizures. The meeting was over two and half hours long. An excessive amount time was spent on discussing findings from assessments that should have had more in-depth discussion regarding problems or unresponsiveness to goals prior to the ISP. The team did not have a sufficient understanding between a choking (mechanical) and aspiration. The physician in attendance at the meeting provided information to assist the team in making a determination of level of risk for choking and aspiration. The facility should consider strengthening the relationship between the various risk rating groups to ensure accuracy of the determine risk ratings.	
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.	<u>Medication Administration Training</u> The monitoring team found documentation that the training for Mandated Medication Administration was conducted as an integrated classroom/competency based training with check offs; taught together by Nursing and Habilitation Therapies. The monitoring team reviewed the facility's documentation dates of the training along with the signature rosters. The facility provided documentation that 100% of RNs and LVNs had completed the training, and that the Mandated Medication Training was incorporated into the new orientation. The Nursing Competency Based Training Curriculum Policy, dated August 2010, was problematic. The policy indicated only RNs and LVNs who routinely administered medications would receive quarterly medication pass observations. The monitoring team was curious as to how the standards for RN Managers/Supervisors/Nursing leadership who are charged with providing supervision of medication passes and corrective actions maintained their competency. Additional information found in the document request regarding medication observations competencies was also in conflict with the policy for the number of times medication passes would be completed prior to moving to six month medication passes. The Nursing Department should revise its policy to reflect the actual practice was being conducted. <u>Administration of Medications</u> The monitoring team during the week of the visit, observed medication passes in various units, and at various times of the day. The monitoring team was accompanied by a member of the Nursing Leadership staff for all medication pass observations.	Noncompliance

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		The monitoring team selected and conducted 30 unannounced medication administration pass observations for 10 different individuals. These observations included administration of oral medications, crushed medications, medications via tube, and medication administered with different mediums, such as applesauce, puddings, and thickened liquids. The monitoring team observations included applying the "essential items" from the facility's Medication Observation Pass Form and found: • Two of 10 (20%) individuals participated in his or her own hand hygiene prior to receiving their medications • Three of five (60%) nurses followed infection control practices when administering medications • One of five (20%) nurses, prompted the individuals to participate in his or her own hand hygiene prior to receiving their medications • Ten of 10 (100%) individuals were identified • 29 of 30 (96%) observations followed the individual's PNMP. One required prompting by a member of the nursing team in attendance • 30 of 30 (100%) observations found each medication was checked against the MAR, prior to administration. • 30 of 30 (100%) observations found medications were administered according to prescription in terms of right drug, right dosage, right time, right form of drug, and right route. The monitoring team during the medication passes questioned the nurses regarding nursing policy/procedure when crushing of medications, of which all of the nurses provide a correct response. The monitoring team's findings were similar to the facility's medication pass observations that also included negative findings. For example, following acceptable infection control practices (e.g., cleaning of the pill crusher). <u>Documentation</u> • Ten of 10 (100%) individual's observed MARs showed that all prescribed medications were administered, as prescribed and initiated. • Ten of 10 (100%) MARs did not contain omissions (blanks). <u>Storage and Security of Drugs</u> The monitoring team conducted focused reviews for inspection of medication rooms and stock medications, and found all medications were properly stored and secured. Controlled substances were observed as doubly secured and accounted for by nurses.	

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		The monitoring team clarified from the last visit with the CNE regarding access to Medication Rooms and Medication Carts. She reported that only the nurse who was assigned to administer had access to the medication cart or cabinets containing medication. The monitoring team visits of various medication sites found this to be the standard that was being followed. <u>Oversight and Monitoring</u> The monitoring team reviewed the facility submitted audits conducted for medication room inspections, and refrigerator temperatures and found: • Two of 15 (13%) of the Refrigerator/Room Temperature Monitoring records included a reference for the established acceptable temperature perimeters. • Zero of the Refrigerator/Room Temperature Monitoring records included a place for documenting actions taken for temperatures falling outside the acceptable temperature perimeters. • Fifteen of 15 (100%) Unit Medication Room Audits were conducted for 12/13 • Eight of 15 (53%) Medication Room Audits were compliant with each of the 29 indicators. • Six of 15 (40%) Medication Room Audits had adequate plans of corrections with timely completion dates. Some of the Medication Room Audits were problematic as there was a lack of correlation between the Medication Room Audits and the Refrigerator Temperature Monitoring Records. For example, Home 506 review of 12/23/13 reported the refrigerator temperature at 36-46 degrees F, did not correlate with the corresponding date of 12/8/13 where the temperature was recorded at 28 degrees F. The facility should ensure the nursing staff are reviewing the temperature logs as a part of the Medication Room Audits. The monitoring team reviewed 10 of the most recent medication variances and associated MARs, and applicable Medication Excess/Shortage Record, Count Sheets for Individual #45, Individual #36, Individual #370, Individual #527, Individual #50, Individual #573, Individual #218, and Individual #447. • Of the 10 medication variances, three (30%) occurred for Individual #447. The medication variance data indicated that he did not receive his prescribed medications to treat his health problems of dysuria, spasticity, and low weight. • Three of 10 (30%) of the medication variances were discovered within 24 hours. Of the remaining eight discovered variances, one was 58 days, one was 31days, two were eight days, one was four days, and two were two days. • Medication Trends by home: 559B had four of 10 (40%) • Seven of seven (100%) of the variances were classified as administration variances	

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		• Seven of seven (100%) of the administration variances included the date and time of notification to the physician • Four of seven (57%) described how the administration variances occurred. • Four of seven (57%) administrative variances contained corrective actions that included supporting the nurse through mentoring The monitoring team also reviewed the last six months of reports addressing medication variance and plans of correction for nursing. The monitoring team found more frequent statements of "nurse counseled." The data did not sufficiently categorize the counseling, for example, instructions on the five rights. The facility should implement systems that more efficiently categorize the counseling in order to determine if training/educator or mentorship provided are effective. <u>Medication Variance Meetings</u> Medication Variance meetings were scheduled for six of six (100%) of the past six months and were held monthly. The September 2013 meeting minutes noted that the facility had attended another facility's medication variance committee meeting for the purpose of gaining insight of their areas of compliance. The minutes listed the items for which there were actions steps regarding attendance/participation of the Medical Director, Physicians, Direct Care RNs and LVNs. The 10/13 through 12/13 meeting minutes had omissions as to the status of those actions steps. The monitoring team attended the Medication Administration Variance Committee Meeting chaired by the Chief Nurse Executive on 1/15/13. The meeting was attended by the Nursing Operations Officer, Nurse Managers, QA Nurses, Clinical Services Director, Pharmacy, and two physicians. Most of the meeting time was directed toward discussions regarding their transcription variances, and regarding the absence of a structured system for check and balances to ensure orders were timely and accurately transcribed to the Medication Administration Record (e.g., 24-hour chart checks). The committee, as a result of their discussions, planned to initiate a Corrected Action Plan (CAP). The monitoring team will follow-up at the next visit regarding the CAP. <u>Pharmacy and Therapeutics/Polypharmacy Committee Meetings</u> The monitoring team attended the Pharmacy and Therapeutics committee meeting, which included discussions and Review of the Guidelines for Management of GERD prepared by pharmacy of which a number of steps evolved in response to the study by the committee: • Instructions for the use of Proton Inhibitors (PPIs) will be added to the MAR • Nursing and Pharmacy will develop processes to disseminate information from	

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		the guidelines to nursing staff • Pharmacy will assess by creating an alert to ensure orders meet criteria for specificity (e.g., powder or granules of the PPI). The discussion of Adverse Drug Reactions during the meeting confirmed that nurses may also submit an ADR to pharmacy. Two of the cases indicated the individual received orders for an antidote, which should have prompted an initiation of an ADR. The reason nurses may not be alert to any responsibilities in initiating an ADR, according to the CNE, attributed to a lack of ongoing refresher training and education on the process for initiating ADRs. The CNE reported she plans to follow-up regarding training on the ADR process. The monitoring team also attended the Polypharmacy Committee where routinely there was not representation by a member of the Nursing Department. For this meeting, however, the CNE was in attendance. There was much information to be learned and shared from this committee about the individual's risks associated with his or her medications. The monitoring team recommends that a member from the Nursing Team or, if possible, the individual's RN Case Manager be in attendance. See section N of this report for more information. <u>Collaboration/Communication Between Nursing, Pharmacy, and Medical</u> The monitoring team reviewed the last six months of communication between nursing, medical, and pharmacy and found examples of communication for: • Clarification of Medication Variance Policies, Example Medication Variance • Findings from Med Station Inspections (e.g., refrigerator temperatures that fell outside established temperature perimeters) • Dispensing of a new liquid narcotic (e.g., CNE requested graduated bottle in order to document usage/accountability of the scheduled drugs) The monitoring team also found collaboration between nursing, pharmacy, and physician for Individual #163. The communication indicated the individual and his family's primary language was Spanish. There was documentation of the planning around his medications for his home visits, which included how the medication order would be written, drugs dispensed, and training and education provided. For example, the facility planned the utilization their LSSLC bi-lingual nurse to provide training to the individual, and the family. The monitoring team did not find documentation of when a medication error was reported and/or discovered. There was no ongoing system for reviewing the medication variances with a team of all disciplines (i.e., nursing, medical, and pharmacy) prior to	

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		making a determination of the severity of the error and what actions the team took to lessen those outcomes. The monitoring team, however, did attend a Nursing Meeting where the CNE, NOO, Nurse Managers, and Nurse Educators brought forth their weekly medication variances to further investigate as to what may have occurred, and discuss alternative education needs. While the efforts by nursing were positive, it remained to give the appearance that Nursing continued to be the sole owner for the medication variances. 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 that there are quality assurance processes that can improve upon the core processes of the medication use system (prescribing, dispensing, transcribing, and administration). 2. Review section N8 of this report. The monitoring team was not in agreement with the facility's self-assessment of substantial compliance because of an absence of a fundamental medication safety system to ensure checks and balances in the completion of physician orders to resolution, a reliable system for medication reconciliation/verification of physician's orders, transcription of the orders, and administration of medications.	

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: #012: Pharmacy Services Policy and Procedures, 12/11/13 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 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, 1/29/13 o Pharmacy and Therapeutics Committee Meeting Minutes, 2013 o Medication Variance Committee Meeting Minutes, 2013 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #86, Individual #582 Individual #344, Individual #286, Individual #532 Individual #201 Individual #267, Individual #551, Individual #22, Individual #258, Individual #319, Individual #323, Individual #365, Individual #212, Individual #526 Individual #218, Individual #93, Individual #516, Individual #501 Individual #410, Individual #529 Individual #28 Individual #334 Individual #327, Individual #535 o MOSES and/or DISCUS Evaluations for the following individuals: • Individual #86, Individual #582, Individual #344, Individual #286, Individual #532, Individual #201, Individual #267, Individual #551, Individual #22, Individual #258, Individual #126, Individual #395, Individual #108, Individual #361, Individual #28, Individual #571, Individual #265, Individual #298, Individual #106, Individual #215, Individual #152, Individual #301, Individual #485, Individual #88, Individual #547,

	Individual #90, Individual #124 Interviews and Meetings Held: o David Leeves, RPh, Pharmacy Director o Janet Way, PharmD, Clinical Pharmacist o Laura Luna, RPh, Staff Pharmacist o Andra Self, Clinical Services Director 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 looked at several areas reviewed by the monitoring team, but in some instances the types of metrics used differed. For example, provision N4 should assess compliance with all recommendations made by the pharmacists. This requires an assessment of the physicians' responses to prospective and retrospective recommendations. The self-assessment reviewed only responses to the QDRRs. In the case of provision N5, high compliance rates for completion by the prescribers were documented. An overwhelming majority of the documents reviewed by the monitoring team lacked the prescriber review. In moving forward, the pharmacy director, clinical pharmacist and clinical services director should review this report and take note of the comments and recommendations. Future self-assessments should include metrics that are more in alignment wit those used by the monitoring team. The facility found itself in substantial compliance with provision items N1, N3, N4, N5, N6, and N7. It found itself in noncompliance with N2. The monitoring team found the facility in substantial compliance with provision items N3. It found the facility in noncompliance with provision items N1, N2, 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, clinical pharmacist, part time clinical pharmacist, and four technicians. The clinical pharmacist began working on 9/1/13. The information for all staff that had worked in the department since the last visit was not submitted. It was reported that there was no clinical pharmacist for three months and a series of contract pharmacists worked during that time. As a result of inconsistent staffing, there was very little progress seen in the provision of pharmacy services. Some areas, which were observed to improve during the last compliance review, demonstrated regression. The pharmacists were documenting the communication with providers. While the documentation of the communication improved, resolution of the clinical interventions was not always documented. Intelligent Alerts did not appear for some frequently used medications, which called into question the functionality of the IAs at LSSLC. The facility struggled to complete the QDRRs. Compliance with timelines was low, but was improving. The staffing pattern in the pharmacy resulted in QDRRs being completed by many individuals over the past six months. The most recent reviews demonstrated improvement in the clinical content. The MOSES and DISCUS evaluations were completed by nursing staff. The psychiatrists completed the required reviews. There were problems with the evaluations since the implementation of AVATAR. Under reporting of ADRs continued. Many suspected ADRs were identified in the QDRRs and other documents, but no ADR form was completed. The facility completed two DUEs since the previous compliance review. The format of the reviews was not consistent with that of a typical DUE. Nonetheless, the reviews provided useful information. The major problem with the DUEs was that problems were identified, but no clear plans of correction were documented in the Pharmacy and Therapeutics Committee minutes. LSSLC continued to report medication variances and prescriber reporting was increased. The facility had yet to address some major problems that contributed to administration variances and medical participation in the variance system continued to be negligible.

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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	LSSLC made progress in documenting communication between the pharmacists and prescribers. The pharmacy director submitted several documents as evidence of this communication: (1) review of physician orders, (2) notes extracts, and (3) single patient interventions. The review of physician orders was a chart that included the date of the order, name of individual, medication involved, reviewing pharmacist, physician, and method of communication, physician response, and outcome. It was primarily utilized to document problems related to order writing, such as incomplete orders, missing	Noncompliance

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	and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	indications, or wrong strength. During interviews, it was determined that this log tracked communication between the pharmacists and nursing staff who contacted the prescribers for order clarification. Therefore, the documentation should indicate the staff that the pharmacist actually contacted by phone. The presentation book included one example of a documentation form for review of physician orders. That form was completed by the pharmacist. It documented a discussion with the staff (assumed to be nursing) that clarified the order with the prescriber. From June 2013 through November 2013, there was a total of 84 contacts. The average for the 6 months was 14. There were 21 clinical interventions documented in the Notes Extracts from 6/1/13 to 12/5/13. The document request included a list of the interventions that noted the recommendation, prescriber that received the recommendation, assessment, and medication. The presentation book included copies of the single patient intervention reports, which provided information on the outcomes of each intervention. This information should have been included in the document request. The majority of interventions were related to drug-drug interactions. One was listed as medication monitoring, but was actually an allergy warning for the use of Rocephin in a PCN allergic individual. The reports were initialed and dated by the prescriber indicating that they reviewed them, but there was no indication of the response of the prescriber to the recommendations. For several interventions, the outcome was unknown. The following are a few examples of the types of interventions reported: • Individual #354 was prescribed Abilify and metoclopramide, which the pharmacist documented was "contraindicated." The pharmacist recommended watching for increased risk of tardive dyskinesia. It appeared that the medications were considered necessary by the PCP. The use of truly contraindicated medications should have called for additional action by the pharmacist. The prescriber should have received written monographs and documented an explanation for use of the medications in the IPN. If the use of the agents was actually contraindicated, the pharmacist should have sought additional guidance prior to dispensing. • Individual #265, 7/19/13: The pharmacist contacted the prescriber regarding duplicate active ingredients for stomach medications. The prescriber elected to use all three medications. The three medications were not identified in the report. • Individual #120, 10/2/13: A recommendation was made to use a PPI other than omeprazole. While the prescriber initialed the form, there was no documentation of the response to the recommendations. The Single Patient Interventions presented information on a series of drug interaction alerts. The information was listed by stock medications and by individual. There was no	

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		information on how this information was communicated because single patient interventions were not generated for this list. Prescribers were notified of "significant interactions." The pharmacy director also reported that clinical intervention forms were not generated for problems, such as wrong dose or wrong drug. Those were managed as medication variances. Twenty-one interventions appeared to be a relatively small number for a facility with a census of 338. Additionally, it was not clear how data derived from the clinical interventions were utilized. There appeared to be some patterns in prescriber practices, but there was no documentation that this information was utilized for the purpose of improving performance. The clinical pharmacist expressed a desire to improve efficiency by utilizing the WORx system for the documentation of communication. The monitoring team has made no specific recommendations about the system that is to be used for documentation of communication. All requirements have pertained to the content of the documentation, including problem resolution and the need to provide data to medical leadership, so that appropriate corrective actions could be implemented. This provision item also 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. Several documents reported that this list of drugs was expanded, but a revised list was not submitted to the monitoring team. Based on a screen shot included in the presentation book, it appeared that digoxin, ketoconazole, simvastatin, and zolpidem were added to the monitoring list. The IA summary report was reviewed with the pharmacy director. The pharmacy director was uncertain about several issues related to this process and the reports that were generated. A new report was eventually issued. This report included 84 intelligent alerts meaning that 84 new drug orders occurred over a six-month period. The report did not include any alerts for lithium, dilantin, and potassium. This indicated that over a six-month period, there were no new prescriptions or orders that involved a change in dose for any of these medications. That is possible, but would appear to be an unlikely occurrence that was not detected by facility staff. The pharmacy director will need to review this report and ensure that the Intelligent Alerts module is functioning as	

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		required. Overall, there was improvement in this area. The documentation of communication was improved. The clinical interventions did not consistently document resolution of the issues and the overall number was relatively small. The absence of any Intelligent Alerts for drugs that are regularly prescribed raises concern about the functionality of the IA module. Finally, the tracking systems provided data related to prescribing patterns, but there was no clear evidence that this information was used to appropriately address problematic practices with the prescribers. <u>Compliance Rating and Recommendations</u> The monitoring team disagreed with the facility's self-rating of substantial compliance for the reasons cited above. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The clinical services director should develop a plan of correction to address the ongoing issues with physician order writing at the facility. 2. Prescribers with problematic practices should be counseled. 3. The pharmacy director should address the comments noted in the text above.	
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.	Twenty-five QDRRs were assessed to determine the compliance rating for this provision item. The documents were evaluated for compliance with the timelines for completion and content. Over the past six months, the QDRRs were completed by a series of contract pharmacists. The lack of stability in pharmacy staffing resulted in serious delays in completion of the evaluations. It also contributed to considerable variation in the content and quality of the reviews. There were three major concerns identified with regards to completion of the QDRRs: (1) Forty percent of QDRRs completed during the reporting period were done within the required timelines, (2) improvement was needed in the clinical content of the evaluations, and (3) psychiatry providers were not consistently reviewing and signing the QDRRs. Facility management was well aware of the deficiencies in timelines and a corrective action plan was implemented to address the issue. As previously noted, the format varied based on the pharmacist completing the QDRR. Earlier evaluations placed most information in the worksheets and provided comments related to polypharmacy on the report form. The most recent evaluations listed current labs, anticholinergic burden, benzodiazepine use, dates of the recent MOSES and DISCUS evaluations, and pharmacist comments on page one of the report form. This provided a concise summary of data for providers and should make the document more useful. One disadvantage of this format was that lab values were documented by exception. In many instances, this did not provide adequate information.	Noncompliance

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		A number of concerns were identified with regards to the clinical content in the QDRRs: • Diagnostics were sometimes provided with limited information. For example, indicating that an EKG was "abnormal," without providing information that is more specific, was not particularly useful. • Documenting one value of an iron panel did not allow for appropriate use of the data because the interpretation depended on calculation of ratios. • Citing one or two abnormal values of a CBC did not provide adequate information to determine if the abnormalities had any association with medication use. • The pharmacists did not comment on blood dyscrasias and other abnormal values such as CO2. The values were simply listed. Blood dyscrasias, such as anemia and thrombocytopenia, were potentially drug related. A decrease in serum CO2 in an individual who received topiramate could have been secondary to the drug. • Several of the blood dyscrasias and other abnormalities should have been reported as suspected ADRs, but were not. The recommendations of the pharmacists focused on a limited number of topics, such as the use of PPIs and vitamin D. While these were valid recommendations and areas that required attention, there were other prescribing patterns that required attention as well. A substantial number of individuals received iron supplementation and the QDRRs rarely provided adequate commentary on its use or the indication. Iron supplementation should be used for iron deficiency anemia, the etiology of which should be clearly identified. The response to treatment is measured by the response of the hemoglobin and hematocrit. The QDRRs consistently did not comment on the generic diagnosis of anemia and did not usually provide the values of the Hb/Hct or comment on the effectiveness of treatment. It was not clear if continued treatment was indicated even though several individuals with chronic constipation received this medication. The QDRRs reviewed did not make recommendations related to the need to assess for continued use. The monitoring for the use of psychotropic medications, particularly the new generation psychotropics was also inconsistently documented. In most instances, the worksheet indicated the individual was at risk, but the specific criteria leading to this decision were not documented. Many QDRRs lacked documentation of weights, abdominal girths, and blood pressures. In some instances, individuals had more than three criteria for metabolic syndrome, however, the information was presented separately in various sections of the report and was never assimilated into a cogent statement regarding overall risk. It appeared that there was a plan to address this through a revision of the report form.	

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		Documentation for the monitoring for topiramate was another area that was not in accordance with the facility's lab matrix. Topiramate is associated with the development of metabolic acidosis, renal stones, weight loss, and acute glaucoma. The requirements for monitoring weight and eye examinations were usually not noted in the evaluations. Individuals who received medications for treatment of hypertension also did not have documentation in the QDRR of the monitoring parameters, such as blood pressure, heart rate, EKG, and urinalysis. The most recent evaluations made no comments on the effectiveness of treatment/outcomes even when four-drug multi-drug therapy was utilized. The medication regimens for the individuals were very complex. The use of multiple AEDs and psychotropics increase the need for vigilant monitoring and surveillance. The following examples highlight the concerns noted above: • Individual #319, 9/30/13: This individual received Sertraline, which required annual EKG. The QDRR noted the last EKG was 8/12, but no recommendation was made to obtain the yearly EKG. • Individual #74, 9/6/13: This individual received multiple medications, including quetiapine and ergocalciferol. The Vitamin D level was not included in the labs and there was no comment on the status of the compliance with the requirement for eye examinations for quetiapine use. The individuals also had a TSH of .15, but no comments were made on the significance of this value. • Individual #365, 10/17/13: The individual received ferrous sulfate and the CBC and iron panel were both documented as normal. There was no discussion of the etiology of the iron deficiency or whether iron supplementation was necessary for this individual with chronic constipation. The last EKG was documented as 8/12. This individual received lithium, which required that an EKG be completed at least annually. The required urinalysis was also not documented. The individual had a waist circumference of 37 and HbA1c of 6, both of which were considered abnormal. The blood pressures were not documented in the QDRR. The individual should be evaluated to determine if the diagnosis of metabolic syndrome must be made. • Individual #212, 9/30/13: There was no documentation of weight or eye examination as required for the use of topiramate. The eye examination was also required for monitoring of quetiapine. The use of Lisinopril for management of hypertension required additional monitoring, such as EKG, blood pressures, and urinalysis, however, the worksheet indicated NA. It also noted that the individual was not at risk for metabolic syndrome, even though multiple new generation antipsychotics were prescribed. • Individual #526, 10/30/13: There was no documentation of blood pressures or heart rates associated with use of metoprolol. The EKG done 1/2/13 was	

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		reported as "abnormal." This would be important to document for an individual receiving beta-blockers. The last Vitamin D level in December 2012 was 30, but there were no recommendations for follow-up. • Individual #218, 10/217/13: This individual had a platelet count of 96k. The hemoglobin and hematocrit were not documented. This individual was treated with ferrous sulfate and iron studies were reported as normal. The effectiveness of the ferrous sulfate is measured by resolution of anemia, but the values to determine effectiveness (Hb/Hct) were not documented. Not all of the monitoring parameters for metabolic syndrome were documented. The clinical pharmacist noted that the TSH had been at the high end of normal for many years. • Individual #93, 10/31/13: The last EKG was dated on 6/26/12. An annual EKG was required for the use of quetiapine. There was also no documentation of the required eye examination. The QDRR documented the last exam was 3/27/12. There was no recommendation regarding the need for an annual eye evaluation. Blood pressures were not documented for surveillance for metabolic syndrome. • Individual #516, 9/27/13: The individual was treated with Alendronate for osteoporosis. The Vitamin D level was not documented. • Individual #501, 9/24/14: This individual had a subtherapeutic Vitamin D of 17, but no recommendations were made regarding this level even though the individual was treated for Vitamin D deficiency. There were no weights or abdominal girth documented for monitoring of risperidone related metabolic syndrome. The clinical pharmacist noted that no EKG, MOSES, or DISCUS were in the record. • Individual #529, 10/29/13: This individual received four medications for the management of hypertension, but there was no documentation of the effectiveness of treatment (no BPs). The report documented a HbA1c 5.9, AG 41, TG 224, and HDL 38. The individual was noted to be <u>at risk</u> for metabolic syndrome. Recent data for this individual should be reviewed to determine if metabolic syndrome is present. This individual also received ferrous sulfate for anemia. Iron studies were not documented. • Individual #86, 8/12/13: The individual received Vitamin D supplementation and had a sub therapeutic vitamin D level of 26 on 7/24/12. There was no recommendation made by the pharmacist regarding this finding. A level done in January 2014 was 33. • Individual #344, 7/3/13: There was a vitamin D level of 59 in June 2013. There was no comment regarding this value. • Individual #532, 11/15/13: There was no documentation of weights or abdominal girth for monitoring associated with the use of olanzapine. The eye exam was documented in the QDRR as 5/24/11 with the plan to return in two	

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		years. However, this individual received topiramate, which required that annual eye examinations be performed. There was no recommendation to address this. Additional record reviews indicated that the individual actually completed an eye evaluation in May 2013. The section N presentation book included three QDRRs that were completed in late December 2013. While the entire evaluations were not included, the monitoring team noted that these reviews included more recommendations and comments on abnormal findings. Based on that observation, improvement in content should be seen over the next few months. <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 facility must take several actions: 1. Continue the corrective action plan to complete the QDRRs within the specified timeframe. 2. The issues related to clinical content discussed above, should be addressed. 3. The need for psychiatrists to review and sign QDRRs that involve psychotropic medications must be addressed. 4. Polypharmacy for all medication classes must be included in reviews.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs. Benzodiazepines used were listed along with the indication. The findings of the MOSES evaluations were sometimes noted as well. The use of prn meds/chemical restraints is discussed further in section J. <u>Polypharmacy</u> Medication polypharmacy was addressed in the QDRRs reviewed. The monitoring team attended the Polypharmacy Oversight Committee meeting during the week of the review. One positive change was that the clinical pharmacist was serving as the chairperson. Thus, the psychiatry department was no longer controlling the process that was responsible for oversight of psychotropic polypharmacy. Psychotropic polypharmacy is discussed in detail in section J11.	Substantial Compliance

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	antipsychotic medications.	Anticholinergic Monitoring Each of the QDRRs commented on the anticholinergic burden associated with drug use. The most recent format assigned a score to the burden. The plans to address the ACB were usually documented such as management plans for constipation. Monitoring Metabolic and Endocrine Risk The facility monitored individuals for the metabolic risk through the QDRRs. The laboratory matrix included several monitoring parameters, including glucose, HbA1c, weight, lipid panels, and blood pressure. The QDRR reports did not include any specific statement regarding the risk for metabolic syndrome. The worksheets included a section to indicate the risk status of the individual. When risk was indicated, the significant values were sometimes documented. Recent reviews listed current labs on the report form, but there was no organization of information into a cogent statement regarding risk of metabolic syndrome. There was no commentary on risk mitigation when it was clear that the risk outweighed the benefits and medications were required. Another problem was the actual requirements for monitoring. A fasting blood glucose or HbA1c was required annually. Some providers did not obtain HbA1c levels. In response to pharmacy recommendations, one provider responded that a CMP was checked annually. This provided a one-time glucose level that may not have been adequate depending on the risks. Individuals were identified who had three or more risk factors. The medical and pharmacy departments should collaborate to review individuals at risk using current data to ensure that any individuals with metabolic syndrome are appropriately identified and managed. Compliance Rating and Recommendations This provision will remain in substantial compliance. The facility will need to address the important area of monitoring for metabolic and endocrine risk. As noted above, data should be reviewed for those individuals who are risk to make a determination regarding current status. 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.	
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	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the providers' responses to both prospective and retrospective reviews. This has been clearly stated in previous reviews, yet the self –assessment continued to assess only the responses to the QDRRs.	Noncompliance

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	followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Prospective Recommendations Prospective recommendations were generated at the time new orders were written. The recommendations were documented in the Single Patient Interventions and Review of Physician Orders. The outcome of the discussions between the pharmacists and prescribers was not always clear. There were several prospective recommendations that were rejected by the prescribers. The prescriber is not obligated to accept the recommendations of the pharmacists. However, the prescriber is required to "document in the individual's medical record a clinical justification why the recommendation is not followed." Retrospective Recommendations The clinical pharmacists also made formal recommendations when completing the QDRRs. The majority of QDRRs indicated that the prescribers accepted the recommendations of the pharmacists. One problem in assessing this area was the lack of review by psychiatry providers. The following data summarizes the responses of the providers found in the QDRRs: • 24 of 25 (96%) QDDRs included the PCP's signature • 18 of 25 (72%) QDRRs involved psychotropic medications o 6 of 18 (33%) included the psychiatry provider's signature • 16 of 25 (64%) QDRRs included recommendations o 13 of 16 (81%) included psychiatry recommendations o 14 of 16 (87%) included medical recommendations ▪ 7 of 14 (50%) documented agreement by the PCP ▪ 6 of 14 (43%) documented disagreement by the PCP ▪ 1 of 14 (7%) was blank Explanations for disagreement on the part of the PCP were found, but not for every QDRR reviewed. The PCPs sometimes stated that there was no advantage in making a change or that a change was not needed. For example, the clinical pharmacist pointed out that the neurologist recommended a follow-up appointment in one year, but that appointment was not completed. The PCP documented "not needed." The records were not available, but the expectation is that at some point the PCP documented in the IPN a rationale for not following the recommendation of the consultant. The psychiatry providers reviewed only three QDRRs with recommendations. Agreement was noted with two recommendations and one was cited as non-applicable. Compliance Rating and Recommendations This provision remains in noncompliance. In order for the facility to move towards substantial compliance	

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		1. Primary care providers and psychiatry providers must review the QDRRs within the appropriate timeframes. 2. There must be evidence that the medical staff continue to accept and implement the recommendations of the pharmacists. 3. The medical staff should clearly note on the QDRR form a clinically justifiable explanation when recommendations are not accepted. When prospective recommendations are not accepted, a similar explanation should be documented in the IPN.	
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. Maintaining 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 conducted the reviews, the evaluation required review and completion by a physician. The facility submitted a sample consisting of 15 MOSES and 15 DISCUS evaluations. The most recent evaluations included in the record sample were also reviewed. The findings are summarized below: Twenty-three MOSES evaluations were reviewed for timeliness and completion: • 23 of 23 (100%) evaluations were signed and dated by the prescriber • 10 of 23 (43%) evaluations had no prescriber review (blank) • 9 of 23 (39%) evaluations included a statement to "see dictated note" • 4 of 23 (17%) evaluations included other comments related to medication changes Twenty DISCUS evaluations were reviewed for timelines and completion: • 20 of 20 (100%) evaluations were signed and dated by the prescriber • 13 of 20 (65%) evaluations had no prescriber review (blank) • 4 of 20 (20%) evaluations included a statement to "see dictated note" • 1 of 20 (5%) evaluations documented no TD • 2 of 20 (10%) evaluations documented other comments The evaluations were completed electronically via AVATAR. The prescriber review was included in the electronic version of the evaluation, however, it appeared that the medical	Noncompliance

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		staff was not completing the evaluations electronically. The forms were printed and provided to the physicians who reviewed them. The prescriber review did not print on the form if not completed electronically. For the evaluations reviewed, the prescribers added hand written comments. Many evaluations were signed without the addition of any comments, and some prescribers instructed readers to review the psychiatry consults. Generally, the comments did not meet the requirements for the prescriber review. Although these rating instruments served as a valuable source of information, record reviews did not reveal any documentation, on the part of the primary providers, of discussion of this relevant information. The MOSES and DISCUS information did not appear to be reviewed by the neurology consultants, as they made no comments on this information. The monitoring team has and continues to recommend that the primary care providers and neurologists review this information and appropriately utilize it in clinical decision-making. As already noted, the intent of the provision is to ensure that evaluations monitoring for side effects of medications are completed and the information utilized. <u>Compliance Rating and Recommendations</u> The monitoring team disagreed with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the facility must take several actions: 1. The evaluation tools must be completed in a timely and adequate manner. 2. Problems related to the use of AVATAR and the prescriber review must be corrected. 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 reported a total of six ADRs from November 2012 through November 2013. Three ADRs were reported for the reporting period of June 2013 - November 2013. All three involved the development of rashes following the administration of a medication or vaccination. During the Pharmacy and Therapeutics Committee meeting attended by the monitoring team, four additional ADRs were discussed. The monitoring team reviewed P&T minutes from 11/7/13 and noted that there was discussion of an elevated prolactin related to Risperdal. Individual #519 was started on Risperdal on 5/13/13. The medication was discontinued on 6/7/13 due to a prolactin level of 58.4 (5/21/13) and Abilify was started. The individual was asymptomatic.	Noncompliance

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		Follow-up prolactin levels were 18.4 on 7/9/13 and 7.6 on 10/29/13. This abnormality was not considered an ADR even though there appeared to be a causal association between the use of Risperdal and the hyperprolactinemia. Notwithstanding the absence of clinical symptoms, the increase in prolactin was an undesired outcome and the elevation should have been recorded as an adverse drug reaction. The monitoring team noted a consistent practice of failing to report ADRs, such as elevated prolactin levels, blood dyscrasias likely associated with drugs, hypotension, and hypersomnolence. The reporting of suspected ADRs was discussed with the clinical pharmacist during the compliance review, including examples noted during interviews that should have been reported. <u>Compliance Rating and Recommendations</u> The monitoring team disagreed with the facility's self-assessment rating of substantial compliance for this provision item. Overall, LSSLC did not maintain an adequate system for monitoring and reporting ADRs. The number of ADRs reported was relatively small. 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. 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. 5. 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.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N7</td><td>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.</td><td>The facility maintained a DUE calendar and completed one DUE each quarter. Two DUEs were completed since the last compliance review. A DUE based on the 2011 Institutes of Medicine revision of dietary requirements for calcium and vitamin D intake was completed and presented in the November 2013 meeting.

The following was presented as a summary of the guideline data:
1. Supplementation is recommended for bone health for people over the age of 60 to reduce the risk of falls and fracture.
2. There is no evidence of benefit in vitamin D levels greater than 30.
3. Increased adverse effects associated with vitamin D levels above 50.

The dispensing records for all individuals at LSSLC with an order for Vitamin D were reviewed on 9/1/13. The laboratory data for those individuals is summarized below:

<table><tr><th colspan="2">Individuals With Vitamin D Supplementation</th></tr><tr><th>Vitamin D Level (ng/ml)</th><th>% Individuals</th></tr><tr><td><20</td><td>0</td></tr><tr><td>20 -29</td><td>11</td></tr><tr><td>30-39</td><td>44</td></tr><tr><td>40-49</td><td>27</td></tr><tr><td>>50</td><td>18</td></tr></table>
While the IOM cited levels of 20 as adequate in healthy individuals, other major organizations, such as the Endocrine Society, National Osteoporosis Foundation, and International Osteoporosis Foundation suggested that levels of 30 are necessary in higher risk individuals. Many individuals at LSSLC were considered high risk and the monitoring team did not find documentation of a plan to address the 11% of individuals who had levels <30. Similarly, the DUE reported increased adverse effects associated with levels greater than 50, but no plan was noted to address the 18% of individuals associated with these high levels.

A DUE on Guidelines for the management of GERD was presented during the Pharmacy and Therapeutics Committee Meeting attended by the monitoring team. The written DUE provided several pages of clinical information on the management and treatment of GERD. At the very end of the document, a table was presented on the use of medications at the facility. While the clinical information was useful, DUEs are criteria based systematic process for monitoring evaluation and continually improving medication use with the goal of improving medication related outcomes for individuals. Standard DUEs include the objective/scope of the study, information on criteria to be measured, methodology to be used, data, data analysis, and recommendations for corrective actions.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		One of the most critical components of the DUE is the provision of feedback to prescribers for the purpose of implementing corrective actions. Corrective actions should be data driven and could include person specific actions and/or systemic actions. Systems actions range from educational activities, changes in the formulary and treatment guidelines or the need to complete additional DUEs. Most of these will require further discussion and with the medical leadership of the facility and additional actions. The actions that will be required following presentation and discussion of the DUE at the P&T should be documented in the meeting minutes. Documentation should include timelines and responsible parties and follow-up to completion. The LSSLC Pharmacy and Therapeutics Committee meeting minutes documented that a DUE was presented, but did not document the overall findings of the studies or the plans of correction related to the DUEs. <u>Compliance Rating and Recommendations</u> The monitoring team disagreed with the facility's self-rating of substantial compliance. The monitoring team offers the following recommendations: 1. The DUE policy should be revised to include requirements for the basic components of a DUE. 2. The DUE should specify the timeframe that the study is completed. 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. To move in the direction of substantial compliance, the monitoring team recommends the consideration of the following: 4. The facility must ensure that the current DUE procedure is followed, including the requirements for drug selection and approval of data collections forms. 5. There should be evidence that the DUE information is reviewed with the medical staff. 6. 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.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.</td><td>The facility continued to report medication variances. The medication data provided to the monitoring team are summarized in the table below.

<table>
<tr><th colspan="13">Medication Variances 2013</th></tr>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>Nursing</td><td>30</td><td>34</td><td>22</td><td>20</td><td>24</td><td>46</td><td>18</td><td>13</td><td>23</td><td>29</td><td>29</td><td>74</td></tr>
<tr><td>Pharmacy</td><td>5</td><td>18</td><td>6</td><td>19</td><td>15</td><td>17</td><td>9</td><td>2</td><td>6</td><td>12</td><td>10</td><td>20</td></tr>
<tr><td>Provider</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>5</td><td>5</td><td>1</td><td>23</td></tr>
</table>

The reporting of data for providers was an improvement, given that attempts were being made to track prescriber variances. The increase in nursing variances in December 2013 was related to a new plan, which required that documentation of missing initials as variances of omission.

The facility continued to explore ways to reduce the number of mediation variances. Through observations, meeting discussions, and document review, the monitoring team noted the following:
• Progress was reported in the medication room inspections. The problem with incomplete medication room inspections was reported to be resolved.
• There were increased efforts in assessing the outcomes associated with medication variances associated with AEDs and psychotropics.
• Several staff visited a sister SSLC to observe the Medication Variance Committee meeting. Based on these observations, there were efforts at LSSLC to increase participation of medical, psychiatry, direct care RNs, and LVNs in the committee meetings.

Notwithstanding these improvements, there were several areas of concern.
• The number of variances reported was not reflective of the magnitude of the medication variance problem in the facility. A medication variance which resulted in 17 doses of medication being administered (when it should not have been), was counted as one variance. The monitoring team also encountered a significant variance that was unreported. Individual #344 did not receive the correct dose of medication for several months. On 7/3/13, the pharmacist discovered that an order written to add Risperdal .25 mg at bedtime was not received by pharmacy or signed off by nursing. This omission was detected on 7/3/13 and was reported to the treating psychiatrist who re-wrote orders for the medication. The medication variance list did not document this variance, which occurred for three months.
• Omissions remained problematic. It was clear that one source of omissions resulted from the failure to note and transcribe orders. LSSLC did not have</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		adequate checks and balances for this system. This was not a new problem. Although the facility staff could not recollect previous discussions, this had been discussed in previous compliance reviews leading to comments in the September 2013 report: "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." • There continued to be no physician participation in the committee meetings. Two members of the medical staff were present for the meeting attended by the monitoring team, however, a review of meeting minutes documented that for the months of June 2013 through November 2013, no members of the medical staff were present for the meetings. The minutes for the meeting held on 10/17/13 documented a presentation of medical data for the first time. It was unclear who presented the data because the clinical services director was documented as absent. The minutes for the 11/21/13 meeting noted that the clinical services director and PCPs met weekly to discuss and correct medication variances, however there was no documentation of these meetings. There was also no documentation of the corrective actions to address prescriber related medication variances. The document request included a running summary for the pharmacy and nursing departments as part of the analysis report. The medical analysis included comments only for January 2014. • The medication variance data spreadsheet did not include sufficient information to determine the magnitude of the problem. The medications involved, for wrong person incidents, were sometimes not included. It was also difficult to determine the extent of a variance. This information determines the magnitude of the problem. A transcription error that results in one or two missing doses must be scrutinized differently from an error that results in an omission of medication for weeks. Finally, the committee continued to present data in challenging formats and graphs. There is a broad agreement that front line health care professionals benefit greatly from the visual display of data presented in time order. Run charts allow professional to determine if the processes changes that were made result in improvement. It has been shown that this method of analyzing and reporting data is of greater value to performance improvement than other summary statistics than ignore time order. Run charts also provide the foundation for more sophisticated methods of analysis such as control charts.	

#	Provision	Assessment of Status	Compliance
		Compliance Rating and Recommendations The monitoring team disagreed with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The appropriate parties should review every step in the medication use system at LSSLC ensuring that best practices are in place and agency and state policy is being followed. That is, the facility should continue to work on all aspects of the medication use system. When problems are identified, the appropriate corrective actions should be implemented. 2. All clinical disciplines with documented medication variances should maintain the appropriate documentation of the variances, the corrective action plans that address the variances and the follow-up to closure. 3. The comments included in the body of report should be reviewed and addressed.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o LSSLC client list o Admissions list o 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 and P QA Reports o PNMT Meeting documentation submitted o Infection Control meeting minutes o Morning Medical Meeting minutes o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o List of Individuals Discharged from the PNMT in the last six months o PNM spreadsheets o Individuals with PNM Needs o NEO curriculum materials related to PNM, tests and checklists o Annual Refresher curriculum materials related to PNM 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 Aspiration or Pneumonia in the Last Six Months o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals With Falls Past 6 Months o List of Individuals with Enteral Nutrition o List of Choking Events in the Last 12 Months o Documentation related to choking event for Individual #309, Individual #106, and Individual #593. o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o PNMT Assessments and ISPs submitted for Individual #47, Individual #441, Individual #542, and Individual #368.

	o Information from the Active Record including: ISPs, all ISPAs, pre-ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #521, Individual #22, Individual #185, Individual #467, Individual #451, Individual #368, Individual 306, Individual #336, Individual #298, Individual #151, Individual #441, Individual #101, and Individual #47 o PNMP section in Individual Notebooks for the following: • Individual #521, Individual #22, Individual #185, Individual #467, Individual #451, Individual #368, Individual 306, Individual #336, Individual #298, Individual #151, Individual #441, Individual #101, and Individual #47 o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #521, Individual #22, Individual #185, Individual #467, Individual #451, Individual #368, Individual 306, Individual #336, Individual #298, Individual #151, Individual #441, Individual #101, and Individual #47 <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A o April Mettlen, RN o Peggilu Watkins, RD, LD o Rhonda Hampton, MS, CCC/SLP o Vickie McCarley, MS, CCC-SLP o Laura Kunstmann, OTR o Cristen Nerren, PT o Delisa Smiley, PNMPC o Todd Miller, Unit Director Lone Pine o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o ISPA Meetings for Individual #368 o ISP for individual #410 o IMRT meeting

	Facility Self-Assessment: The self-assessment continued to be thorough, though it did not always consistently correlate to all of the elements reviewed by the monitoring team. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapy department continued to demonstrate hard work and a focus on accomplishing their established goals. The facility initially requested full monitoring for Section O1-O5 and O8, with no monitoring for O6 and O7 due to little or no progress. Based on interviews throughout the week of this onsite review, the Director of Habilitation and the monitoring team agreed to conduct full monitoring for O1, reduced monitoring for O2-O5, and no monitoring of O6-O8. Reduced monitoring was accomplished by summarizing activities reported and reviewing the status of some elements using a smaller sample. As such, all areas were found to be in noncompliance by the facility and while the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with the facility's findings.
	Summary of Monitor's Assessment: As in previous reviews, it was evident that some limited progress had been made in many areas. There was a fully constituted PNMT with all team members consistent with the previous onsite review (with the exception of the RN, who was new since September 2013). April Mettlen was a strong choice and impressed the monitoring team with her knowledge and leadership skills. She met with the monitoring team to discuss the Settlement Agreement, the PNMT, and other issues related to timeliness and documentation. The PNMT was encouraged to track PNM-related events for individuals as they occurred through IMRT, morning meetings, and other routine meetings to determine when and if they recognized individuals who met criteria for referral to the PNMT. It would be important that they could access the episode tracker used by QA in real time as it was updated. Observations during mealtimes were conducted and there were noted improvements in Woodland Crossing and Lone Pine. There continued to be significant concerns, however, in Castle Pines. The Mealtime Coordinator system had been implemented, but there was not consistency across homes, that is, the process was applied differently across each unit. There was a need to formally standardize the system, but permit some flexibility to adapt to the different environments in each unit. This should be clearly established via written protocols. Of course, extensive training and monitoring continued to be necessary for adequate implementation and to sustain competency for all staff roles. Though this was reported to be in place in Castle Pines, both staff and the staff "charge," made potentially serious errors that were identified and that required the monitoring team to intervene to ensure individual's safety. At Lone Pine, it was very positive that Todd Miller and his staff had taken this process very seriously and it was evidenced by excellent performance by staff. This was a significant improvement from previous reviews.

	Concerns were repeatedly highlighted throughout the week related to failure to take proactive steps to prevent issues for which individuals were clearly at risk (e.g., falls). Aggressive fall prevention is the key issue, rather than merely responding to falls as they occurred. For instance, all environments should be evaluated for potentially dangerous hazards, even if no one had yet fallen (as appeared to be an approach at LSSLC as described by some staff). Further, all team members must advocate for supports and services to be implemented to address health and safety issues for individuals they know to be at risk (Individual #368's cataract surgery, for example). Further, a number of individuals were observed wearing poorly fitted clothing and shoes. In more than a few cases, individuals were observed with their pants falling down around their hips, knees, and ankles. Staff had to be prompted to assist in pulling them up in some cases. Shirts were over-sized and hair was uncombed; individuals did not look neat and well-attended to. PNMPs were missing key information and the pictures submitted were not clear to serve as an easy reference for staff. It was assumed that the original plans were in color, though these should be reviewed for clarity and steps taken to ensure that black and white copies are not available to staff. Plans should continue to be audited to address the weak areas highlighted below. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 13 individuals, 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 four individuals who were assessed or reviewed by the PNMT over the last six months for whom assessments were submitted. Some of these were duplicates from Sample O.2.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly	LSSLC formally operationalized the state PNM policy as of 6/1/13. • The facility did not have a single comprehensive PNM policy that addressed the scope of PNM issues outlined below, nor were each of the following elements specifically outlined through a combination of facility policies, guidelines and procedural documents to generally outline a complete and comprehensive system of Physical Nutritional Management: o Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); o The annual review process of an individual's PNMP as part of the individual's ISP; o The development and implementation of an individual's PNMP shall be based	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; o The roles and responsibilities of the PNMT; o The composition of the facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; o Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); o The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; o Requirements for continuing education for PNMT members; o Referral process and entrance criteria for the PNMT; o Discharge criteria from the PNMT; o Assessment process; o Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; o The PNMT consultation process with the IDT; o Method for establishing triggers/thresholds; o Evaluation process for individuals who are enterally fed; o PNMT follow-up; o Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; o A comprehensive PNM monitoring process designed to address all areas of the PNMP, including: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, ▪ Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), ▪ Identification of monitors and their roles and responsibilities, ▪ Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, ▪ Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the	

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		relevant supervisor or clinician, and ▪ Frequency of monitoring to be provided to all levels of risk. o A system of effectiveness monitoring; and o Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. <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. The nurse currently on the team was newly added since the previous review following the resignation of the previous RN. Team members included the following with start dates: • April Mettlen, RN (9/1/13) • Peggilu Watkins, RD, LD (4/1/12) • Rhonda Hampton, MS, CCC/SLP (12/1/11) • Vickie McCarley, MS, CCC-SLP (1/1/13) • Laura Kunstmann, OTR (4/1/13) • Cristen Nerren, PT (2/1/13) • Delisa Smiley, PNMPC (5/1/13) Back-ups to the core team members had been identified for the RN, PT, and OT. The two SLPs often attended the meetings, but also served as back-ups for each other. There did not appear to be a back-up identified for the RD at the time of this review. <u>Consultation with Medical Providers and IDT Members</u> A number of medical providers including nurses, physicians, psychiatrists, nurse practitioner, physician assistant, and pharmacists were listed as medical consultants, though none was listed as primary. Based on the documentation submitted, there were 27 meetings held between 6/4/13 and 1/9/14, and one meeting observed by the monitoring team during the week of this review, for a total of 28 meetings. There were no meeting minutes submitted for a meeting held on 10/30/13. No physicians, or others listed as medical consultants, attended any meeting during that period. Effective medical consultation, support, and involvement was not consistently provided in other ways. Though by report, the PNMT RN or designee attended daily clinical medical morning meetings, there was no evidence of attendance by the PNMT or other Habilitation Therapy representative at infection control meetings, skin integrity meetings, or others in which the physicians and/or nursing also participated consistently.	

#	Provision	Assessment of Status	Compliance
		Daily Medical Provider Meeting minutes were submitted for 6/3/13 through 12/3/13. Though these meetings were to be held daily, the minutes reflected numerous duplications in dates throughout the copies submitted. Attendance by the PNMT representative was recorded for 66 of 110 meetings (60%) and 13 others attended by the Habilitation Therapies Director, for a total of 72% attendance overall. The reports from these meetings should be routinely discussed by the PNMT in order to update the status of individuals on their caseload, to track others with PNM concerns, and to identify individuals who met criterion for referral to the team. As such, consistent attendance was critical by the nurse or designee. The PNMT RN also served as the liaison between the PNMT and the physicians by personally meeting with them to discuss pertinent issues and to ask questions, as indicated. • For 5 of 28 PNMT meetings (18%) held from 6/5/13 to 1/9/13, there was evidence of participation by IDT members, however, as described above, IDT therapists attended some meetings in the absence of a core team member. The PNMT consistently reviewed their findings with the IDT upon completion of the assessment and routinely attended IDT meetings related to individuals they reviewed or who were referred to the PNMT. <u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: • 5 of 6 core team members (83%) were currently licensed to practice in the state of Texas per online verification. The license for the dietitian could not be verified online based on the number provided. Delisa Smiley was well qualified for her role as a PNMPC and made a significant contribution to the team function, but was not a licensed clinician. • 3 of 6 core PNMT members (50%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. The PT was a new graduate in 2012 completing her clinical affiliations in August 2012 before her employment at LSSLC and her assignment to the PNMT on 2/1/13. The nurse had worked in an eye center and in medical surgical care, though she had been a nurse since 2003. It was reported that she had served as a nurse case manager at LSSLC before her assignment to the PNMT on 9/1/13, but the details were not described under professional experience in her CV. The OT listed graduation in 1983, but her degree at that time was not listed and dates of her work experience were not identified in her CV. As such, the extent of her experience was not known. The professional experience documented by both SLPs and the dietitian was significant. • 6 of 6 licensed PNMT staff (100%) had completed continuing education directly	

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		related to physical and nutritional supports and transferable to the population served within the last year (a notation indicated that the education listed was since the previous review, though the request was for the last 12 months). Back-up team members were listed with no related continuing education in the last year. No training or continuing education was listed for the PNMPC, though she was listed as a core team member. A number of relevant courses were attended by team members: • Vickie McCarley, MS, CCC-SLP (22 contact hours in the last year) • Rhonda Hampton, MS, CCC-SLP (10 hours in the last year) • April Mettlen, RN (19.5 contact hours in the last year) • Cristen Nerren, PT (23 contact hours in the last year) • Laura Kunstmann, OTR (12.5 contact hours in the last year) • Peggilu Watkins, RD, LD (14.5 hours in the last year) Ongoing continuing education related to PNM and transferrable to the population served 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 maintained by the team with one exception (10/30/13). • Since 6/4/13, PNMT meeting minutes submitted generally included (a) referrals, (b) review of individual health status, (c) PNMT actions, and (d) follow-up. Goals, exit criteria, and updates related to outcomes/progress toward established goals and exit criteria were not consistently stated. Meeting minutes were submitted for 6/4/13 to 1/9/13 (a total of 27 meetings). A signature sheet of attendees was included for most of these. • Since the last onsite review, the team met at least weekly for 27 of 32 weeks (84%), missing the weeks of the Christmas and New Year's holidays and three additional weeks in June, July, and August 2013. Based on review of the minutes for 26 meetings for which minutes and sign-in sheets were submitted, attendance by core PNMT members and/or back-ups for the meetings conducted during this time frame was: • RN: 25/26 (92%) by core member, 0/26 (0%) by back-up, and 92% overall. • PT: 21/26 (81%) by core member, 1/26 (4%) by back-up, and 85% overall. • OT: 25/26 (96%) by core member, 0/26 (0%) for back-up, 96% overall. • SLP: 25/26 (96%) by one or both core members • RD: 23/26 (88%) by core member (no back-up assigned)	

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		Attendance was generally above the criterion of 80% for core team and above the 90% criterion overall, with the exceptions of the RD and PT. It was expected that with the absence of any core team member, a back-up would be consistently assigned to attend the meetings. The meeting minutes were maintained in a table format as Individual Meeting Records and included the following elements: • Sign-in sheet • Individual reviewed (referrals and active caseload) • Discussion • Action Step (included in the discussion) • Person Responsible (included in the discussion) • Date due (not consistently documented) • Date done (not consistently documented) • Reason for referral • Exit criteria • Discharge date PNMT goals were not identified. Weight and weight range or other key clinical indicators were not consistently documented. The date of next review was generally included in the discussion section. Each of these should be considered as key elements of the meeting record format. Though an episode tracker was maintained by QA and published monthly, there should be real time access to this information by the PNMT to address identified concerns as they occur. Review of individuals who presented with a change of status and/or presented with health concerns that may trigger a need for referral was an aspect of the system designed by QA, but monthly review may not be timely enough for intervention for an individual with urgent PNM needs. The facility implemented a system of corrective actions to address identified issues and concerns. This system should be integrated with Habilitation Therapies and the PNMT to address the following: • Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; • Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT are collected, trended, and analyzed; • Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the	

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		resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan): o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. Section O requires that the PNMP be reviewed at the individual's annual ISP 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 PNMT. These aspects, though outlined in O1 of the Settlement Agreement, are actually reviewed in O3 below. The facility self-rated this provision in noncompliance 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. It was expected that the attendance by the core team RD would continue to improve with the established criteria of 80%, and 90% with back-up, particularly for the RD and PT. 2. Consistent communication and integration with medical must be consistently demonstrated through attendance at PNMT meetings and PNMT representation at related meetings including the daily medical meeting, skin integrity, infection control, and pneumonia committee. 3. Policies and/or written procedures should address the elements listed above.	
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	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion with the habilitation therapy director, Danielle Perry, AuD, CCC-A while onsite, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample), because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Identification of PNM risk</u> All individuals at LSSLC identified with PNM needs (306 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. Per facility	Noncompliance

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	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.	policy, in the case that it was determined that an individual did not have PNM needs, a PNMP was recommended for termination, but in all cases, a Dining Plan was provided. Per the list submitted, 38 individuals' PNMPs were discontinued since July 2012, and in the case of Individual #594, a PNMP was not issued. These lists were maintained and updated as required. Based on lists of individuals with identified PNM concerns, there were individuals who (a) required physical assistance for positioning associated with swallowing: 108 individuals, (b) were dependent on others to eat: 51 individuals, (c) had difficulty swallowing: 182 individuals, and/or (d) were considered to be at medium or high risk of choking (approximately 219 individuals) or aspiration (approximately 157 individuals). Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), most were listed with a PNMP, with exceptions of Individual #261, Individual #297, Individual #500, Individual #524, Individual #477, Individual #330, Individual #97, Individual #66, and Individual #210. All of these, except Individual #66, were identified at medium or high risk for choking and/or aspiration. Individual #66 was identified as requiring positioning assistance related to swallowing, but was identified at low risk for both choking and aspiration. Per policy, each of these individuals should be provided a Dining Plan, which would address their risk at mealtimes. The need for a PNMP should be reviewed for each of these individuals to ensure that these risks do not extend into other activities, thus requiring a PNMP. In the case of Individual #66, her need for positioning assistance would generally require a PNMP. This case should be reviewed to ensure her PNM needs were met. There were four incidents of choking documented since the last monitoring review: Individual #106 (8/7/13 and 10/2/13), Individual #593 (8/29/13), and Individual #309 (9/26/13). Each of these events resulted in staff performing abdominal thrusts (Heimlich). It was also understood by the monitoring team that Individual #106 had experienced a third choking event in December 2013. Though he was identified at high risk for choking by his IDT at the time of this review, the plan in place was ineffective in preventing this serious and potentially deadly concern. Individual #593 was identified only at medium risk and Individual #309 was identified at low risk. Further, Individual #309 was not provided a PNMP. Follow-up documentation was submitted as follows: • Individual #106 (8/7/13): There was no evidence that a SLP conducted a mealtime observation to assess his plan until 8/9/13, after the IDT met for a Change in Status. The IDT plan included that monitoring by the PNMPCs was to be conducted two times daily for 30 days, a chairside assessment was to be conducted by 8/19/13 (10 days after this serious event), with random monitoring by Habilitation Therapies with quarterly review. No changes were made to his plan or supervision, prompts, or cues. It was reported that a quarter-	

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		sized piece of chicken that was un-chewed was expelled with the abdominal thrusts. His plan indicated that he was on pre-cut foods with chopped meats (half-inch size). Clearly a quarter-sized piece of meat did not match this order. There was no evidence of staff training that occurred related to this error. There were 46 monitoring sheets submitted for review from 8/12/13 through 10/2/13. Per one form, 8/19/13, he refused to eat breakfast or lunch, so the form was not completed. On 8/20/13, the form stated only that "ate good," but staff compliance with the plan was not addressed. The form completed on 8/7/13, was incomplete. On three occasions, staff compliance was 100%, yet on 40 forms (87% of the total completed) compliance was rated as 90% with the same missed element: staff had not been trained on his individual plan. • Individual #106: (incident listed as occurring on 10/3/13, but it was reported as occurring on 10/2/13 per the ISPA dated 10/2/13). There was no evidence of a SLP assessment, but rather an ISPA form outlining recommendations for changes to his plan. After this second choking event, changes were made to his Dining Plan to include no ice (he choked on this), moistened dry cereal, chopped foods with ground meat that is moistened with sauce or gravy, and soft cooked vegetables and fruit. There was no evidence of assessment to establish the rationale for these changes. Other changes were added to his PNMP, addressed in a second ISPA form on the same date. It appeared that the new instructions were handwritten on 10/2/13 to ensure timely implementation. Because a more current PNMP was not submitted, it was not clear that these changes had been made permanently to the plan in a timely manner. • Individual #593: By report, the choking event occurred on 8/29/13. There was no evidence of SLP assessment, other than a physician order written by the RD on 9/3/13 (at least four days later). Diet order changes were outlined based on the SLP chairside evaluation per this notation. The note indicated that the changes should be made immediately due to "safety concerns." It was of serious concern that the changes were not made based on an assessment by the SLP prior to, or at the time of, his next meal following the choking event. His PNMP was not updated until 9/4/13. Again, significant diet order changes were made with no evidence of assessment and ISPA. An event of this nature should involve the entire IDT, meeting to address all viable solutions within 24 hours. The monitoring forms submitted (four) that were completed from 8/30/13 through 9/4/13, again indicated that staff had not been trained on his plan. Further, the monitor reported, in each, that he ate at a fast pace and over filled his spoon. By report, staff attempted to prompt him, but was not successful. There was no evidence of further staff training or changes to his plan to address these. The plan stated only that staff should provide verbal tactile prompts to slow down eating pace and to minimize overstuffing. The SLP sent an email to the OT to address the need for adaptive equipment because she did not know Individual #593 well. It was of	

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		significant concern that there was no clear collaboration at the time of the assessment or after to minimize his risk of future choking events. • Individual #309: Per the Unusual Incident Report, the IDT met related to this incident the day after this incident on 9/27/13, but no documentation was submitted for review as requested. It was also reported that the IDT recommended that a chairside evaluation should be completed. It was not clear when this was conducted and there was no documentation. Monitoring forms were completed on 11/4/13 and 11/7/13. In both cases, the plan was not followed, with very poor compliance across a number of elements. There was no evidence that staff were trained or other follow-up occurred after his choking event or after these reviews by PNMPCs. There was no evidence that the PNMT had reviewed any of these cases. <u>PNMT Referral Process</u> Per the LSSLC Physical Nutritional Management policy, individuals identified by the IDT who were at high risk as defined by the At Risk policy (#006) and for whom the IDT was not able to achieve a satisfactory outcome or remediate the risk level, may be referred to the PNMT by the PCP, PNMT, or IDT for assessment and recommendations for interventions and supports. More specific criteria guidelines were outlined, though individual circumstances and risk levels would dictate more or less stringent criteria: • Two choking episodes 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: o Aspiration Pneumonia; o GI Issues o Fractures; o Skin Integrity; and o Seizures • New or proposed enteral feeding; • Unresolved vomiting (more than 3 in 30 days, not related to viral infection); • Significant/unplanned/verified weight loss or gain of o More than 5 pounds in one month; o 3 or more pounds per month for three consecutive months or 7.5% of body weight per month for 3 consecutive months; or o 10% of body weight in 6 months; • Any Stage III or IV decubitus, or any Stage II with delayed healing; or • Fracture of a long bone, spine, or hip	

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		There were no established timelines within which to review and determine a need for PNMT involvement. Training had been provided to IDTs in the past. There were seven individuals listed on the current active caseload for the PNMT (Individual #336, Individual #306, Individual #542, Individual #441, Individual #47, Individual #560, and Individual #368). It could not be determined from the list submitted how many of these were self-referred versus those referred by their IDT, or when those referrals occurred. The PNMT did not maintain an episode tracker or log. The episode tracker maintained by QA was available on a monthly basis only, though this tracked the incidence of health issues that may have required referral to the PNMT. Ideally this should be recognized by the IDT in a timely manner, though the threshold system implemented by the facility was intended to provide safe-guards when an individual reached the established threshold related to incidence of a particular health issue. Referrals not already made to the PNMT were to be made via this system. As the PNMT did not review cases of individuals not already referred, it did not appear that they had a mechanism by which to anticipate this need. For example: • Of the 29 individuals listed with a 10% or greater weight loss in the last six months, only three had been referred in the last year. • Of the 25 individuals listed with pneumonia in the last six months, three were listed with two incidences each (Individual #357, Individual #47, and Individual #240). While these were not listed as aspiration pneumonia, five of the six cases were categorized as bacterial and, as such, aspiration could not be ruled out as a factor, particularly because each was enterally nourished. There were two cases cited as aspiration pneumonia (Individual #203 and Individual #185). Though the policy listed two incidences of aspiration pneumonia as a criterion for referral, the monitoring team encouraged the facility to consider any case of aspiration pneumonia (and multiple occurrences of pneumonia of any type) to be a sound rationale for timely referral to the PNMT. There were other cases of pneumonia-related hospitalizations that were not included on the pneumonia list: Individual #172, Individual #24 (2), Individual #214, Individual #286, Individual #52, Individual #36, Individual #102, Individual #354, Individual #405, Individual #22, Individual #33, Individual #361, and Individual #521. The Hospitalization List identified only the reason for admission, and the discharge diagnosis was not included. Of all the individuals listed above, only two were listed as referred to the PNMT (Individual #185 and Individual #240). • Of the seven individuals listed as on the current active caseload for the PNMT, only two were listed as referred (Individual #306 and Individual #542). It was not known if the others were self-referred to the team or if this was an error.	

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		Self-referrals should be documented by the team, as such, but should be differentiated from referrals by the IDT. • Individual #336 had experienced at least 32 falls between 6/8/13 and 11/17/13, yet had only been recently added to the PNMT caseload. Individual #368 was listed with 31 falls during that period and again his case had not been referred in a timely manner. Onsite reports indicated that he had fallen as many as 65 times in the last year. Individual #306 had at least 18 falls, yet his referral had not been made in a timely manner. In fact, there were over 30 individuals who had experienced five or more falls in a six month period, yet had not been referred. • There were numerous individuals listed with wounds, skin breakdown, or pressure ulcers. • It was noted that there were at least 84 individuals with gastrostomy or gastrostomy/jejunostomy tubes, with 12 of those placed in the last year and at least half of those placed since the previous review. Of those placed in the last year, only two had been referred to the PNMT (Individual #27 and Individual #285). Though there were no timeframes outlined in the facility policy, referral within five days of an incident warranting review by the PNMT should be made by the IDT or as a self-referral by the PNMT. There were two individuals who had received enteral tube placements since the previous review (Individual #285 and Individual #216). • 1 of 2 individuals who received a feeding tube since the last review (50%) had been referred to the PNMT prior to the placement of the tube. The following metric was not applied as the circumstances of tube placement could not be determined based on the documents submitted: • __ of __ individuals who received an emergency feeding tube placement (%) since the last review had been referred to the PNMT after the emergency feeding tube placement. Incidence of conditions in various PNM-related risk areas were not tracked by the team even though consideration of at least the following issues for tracking was indicated: • Weight loss/gain • Fractures (long bones, pelvis, spine) • Skin Breakdown • Pneumonia • Recurrent aspiration • Respiratory compromise • Constipation • Bowel Obstruction	

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		• Fecal impaction • Recurrent bowel related concerns • GI issues • Dehydration • MBSS • Choking • New or Possible Enteral Tube Placement • Feeding tube clogged • Poor oral hygiene • Urinary tract infection • Hospitalizations/Change in Health Status • Other <u>PNMT Assessment</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. Assessments submitted included the following (dates are signature dates, when available): • Individual #351 (6/5/13) • Individual #336 (7/3/13) • Individual #151 (6/18/13) • Individual #172 (5/30/13) • Individual #542 (8/13/13) • Individual #258 (5/7/13) • Individual #361 (6/4/13) • Individual #101 (6/5/13) • Individual #294 (5/15/13) • Individual #382 (6/5/13/13) • Individual #306 (5/3/13) • Individual #23 (unknown) • Individual #47 (10/23/13) • Individual #441 (11/5/13) • Individual #27 (5/7/13) Of these, three individuals were not listed as referred (Individual #258, Individual #47, and Individual #441). Individual #441 and Individual #47 were listed as on the active PNMT caseload, however, per the list submitted. Additionally, Individual #368 was listed on the active caseload and an assessment completed on 1/10/14 was also submitted as	

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		requested. The monitoring team requested assessments completed in the last six months, or since the previous review. Of those submitted, only five had been completed during that period (Individual #336, Individual #441, Individual #47, and Individual #542, and Individual #368). Due to the abbreviated review, only these were analyzed below: • For 1 of 5 individuals (20%), the PNMT assessment was initiated at a minimum within five working days of the referral, per the dates identified in those assessments. • For 0 of 5 individuals (0%), the PNMT assessment was completed in 30 days or less of the date of referral, per the date in the assessment heading. Actual completion dates could not be determined because dated signatures were not included in each assessment. Based on review of this assessment, the following elements were included: • 5 of 5 assessments (100%) contained the date of referral by the IDT (or self-referral). Referral source was not identified. In the case of Individual #368, it was reported that he had been referred for review of falls after a QA document revealed that these were increasing. After reviewing the falls database, the PNMT determined that he would be accepted for services at that time. He had a reported 63 falls since 11/1/12, and it was of concern to the monitoring team that there had not been a referral until 11/7/13. • 5 of 5 assessments (100%) contained the date the assessment was initiated. The first date of assessment was presumed to be the date it was initiated. • 1 of 5 assessments (20%) contained evidence of review and analysis of the individual's medical history. While medical history was addressed the analysis was limited and insufficient, though the assessment for Individual #368 was slightly better than the others. • 0 of 5 assessments (0%) identified the individual's current risk rating(s), including the current rationale. The assessments provided a limited list of risks and/or did not identify the rationale for the level of risk assigned by the IDT. • 0 of 5 assessments (0%) identified recommended risk ratings based on the PNMT's assessment and analysis of relevant data. • 0 of 5 assessments (0%) included an assessment of current physical status. Each of the assessments was completed much later than the assessment data reported in the documents submitted and, as such, was not considered to be current. In one case (Individual #47), copies of IPNs were embedded in the report rather than a summary and integrated analysis of findings included. • 0 of 5 assessments (0%) included a review of musculoskeletal status. Again this information, when reported, was a summary from a previous evaluation or was	

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		not current • 0 of 5 assessments (0%) included an evaluation of skin integrity. • 1 of 5 assessments (Individual #542) (20%) contained a list of medications with potential side effects listed, including drug/drug or drug/nutrient interactions and/or actual side effects. Only two of the assessments reviewed included the intended purpose of the medications prescribed. • 0 of 2 (0%) assessments for individuals who were enterally nourished, identified residual thresholds. • 1 of 5 assessments (20%) included a tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation (Individual #542). • 1 of 5 assessments(20%) contained information about the individual's current respiratory status based on a physical assessment (Individual #47 for head of bed elevation only). • 4 of 5 assessments (80%) contained evidence of observation of the individual's supports at their home and/or day/work programs. This was not clearly evident in the assessment for Individual #368. • 4 of 5 assessments (80%) contained evidence that the PNMT conducted hands-on assessment, though these appeared to be limited. This was not clearly evident in the assessment for Individual #368. • 2 of 5 assessments (40%) identified the potential causes of the individual's physical and nutritional management problems (Individual #336 and Individual #368, though each of these presented insufficient analysis). In some cases, analysis statements were scattered throughout the reports, but never integrated into a clear analysis of findings in order to establish a rationale for the recommendations. • 3 of 5 assessments (60%) identified physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, though analysis and rationale for the recommendations were not clearly stated. • 0 of 5 assessments contained recommendations for measurable skill acquisition programs, as appropriate. • 3 of 5 assessments (60%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP), though it was difficult to discern if the changes were those initiated by the PNMT or merely reported. The assessments took place over such an extended time and it was difficult to track the course of assessment and intervention in the written reports. • 3 of 5 assessments (60%) contained recommendations for monitoring, tracking or follow-up by the PNMT (Individual #368, Individual #542 and Individual #336). Other than a few for Individual #368, most of these recommendations	

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		were only related to monthly follow-up by the PNMT, with no indication that they would have any ongoing responsibility for actions, interventions or monitoring in the interim. There was no documentation clearly outlining PNMT responsibilities for Individual #47 or Individual #441. • 3 of 5 assessments (60%) contained discussion as to whether existing supports were effective or appropriate, though this was scattered throughout the report and difficult to follow. • 2 of 5 assessments (40%) contained the signatures of all core team members (or alternate). The signatures were not consistently dated nor were the date of assessment initiation or completion. In each case, the referral had occurred two (Individual #336) to three months (Individual #47, Individual #441, and Individual #542). In the case of Individual #542, it was reported that he was referred on 5/8/13. The assessment was not initiated for one week. Though he was hospitalized after that time through 6/18/13, the PNMT did not complete his assessment until two months later on 8/13/13. There were no signatures on the assessment for Individual #368. The following elements, among those listed above were not addressed sufficiently: • Discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition. • Dates of signature by core team members (or alternates). • Measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT. The outcomes were identified, but there were no specific indicators for when nursing staff should contact the PNMT. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. • Evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects. • Evidence of review/analysis of lab work. • Nutritional assessment, including, but not limited to, history of weight and height, intake, nutritional needs, and mealtime/feeding schedule. • Evaluation of current assistive equipment. Though listed, there was not a clear and current assessment of effectiveness. The OT/PT assessment sited had been completed five months earlier. • Evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning. Only a head of bed elevation (HOBE) assessment was conducted. The previous OT/PT assessment had been completed five months earlier. • Positioning that may impact PNM status including during bathing and oral	

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		hygiene based on observations of these activities; • Evaluation of motor skills. Objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment's recommendations because they may serve as clues for potential change in status. For example, key clinical indicators should be identified that alert the IDT that the individual may need an increase in intervention or monitoring and may be as basic as vital signs or meal refusals. While the team may establish appropriate discharge criteria, there would likely be other clinical indicators noted before reaching the levels that resulted in the initial referral. There should be efforts to proactively intervene rather than wait for negative outcomes to occur and refer after the fact. • These should be integrated into the IHCPs. • These will not likely be the same objectives for discharge from the PNMT. The IHCPs and PNMPs for individuals with physical or nutritional management difficulties require effectiveness monitoring of individual-specific objective clinical data to determine the efficacy of the interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, if staff were adequately trained, etc. If the team determined that 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/ISPAs</u> • Because the assessments for Individual #441 and Individual #47 were not completed in conjunction with their annual ISPs, there was no evidence of an ISPA held upon completion of the PNMT assessments. In the case of Individual #47, an IPN embedded in the PNMT assessment documented that an ISPA was written to inform the team of the removal of supine positioning from the PNMP based on the findings from the HOBE. It was noted by the monitoring team that this was a standard means to address changes to the PNMP by many Habilitation Therapy staff. The clinicians wrote up the addendum, then circulated it at a morning meeting, for example, for signatures by other IDT members, rather than conducting an actual meeting to discuss issues related to specific changes. While this was an effective method to communicate simple changes, it should be clear that a meeting was not held. In the case of more significant changes, such as this one for Individual #47, a meeting should be held to determine if there were other related issues the IDT needed to consider and discuss, including staff training. • In the case of Individual #336, there was no ISPA meeting conducted to review the findings of the PNMT upon completion of their assessment. The actual completion	

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		date was not known because the signatures were not dated, though the Habilitation Therapies Director wrote a notation that the RN was no longer employed at LSSLC and was unavailable to sign the report (November 2013, actual date illegible on copy submitted). ISPAs documented on 6/3/13, 6/24/13, and 6/28/13 that the IDT had discussed the increase in falls and her unsteady gait. It was reported at that time, that a referral to the PNMT had been made on 5/6/13 (there was no ISPA submitted related to the referral) and that she had been scheduled for assessment on 6/4/13, with results pending. There was no PNMT representation at any of these meetings. The assessment indicated that the assessment had not been initiated until 7/3/13 and appeared to have not been completed until sometime in November 2013. o It was reported, per the ISPA on 12/12/13, that Individual #336 had experienced 29 falls (unknown timeframe), with eight of these resulting in injuries. A fall on 12/11/13 resulted in a serious laceration to her right check requiring seven sutures. It was reported at that time, that Habilitation Therapies would conduct full evaluations due to her changes in status (full time in a wheelchair and suspected ALS). There were no due dates established for the therapy assessments and PNMT was not mentioned, though the nurse and OT were present at the meeting. There were additional ISPAs to make changes in her PNMP after a wheelchair evaluation on 12/17/13. A subsequent ISPA documented another change in status post-hospitalization from 12/27/13 to 1/1/14. There was no evidence of OT, PT, SLP, or PNMT assessments at that time. The first assessment was finally completed on 1/9/13 by OT (clinician also a core PNMT member) who recommended direct therapy and the SLP (clinician also a core team member) who recommended an ISPA to discuss the need for a swallowing study. There was no evidence that this occurred or that the team met to discuss the findings by the OT. The PT assessment was not documented until 1/15/14, at which time direct PT was also recommended with no ISPA noted in her individual record. There was also no evidence that the IDT met to revise the IRRF or IHCP, previously reviewed at her annual ISP on 6/12/13. • There was no evidence that all recommendations by the PNMT were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs for Individual #336, Individual #47, or Individual #441. There was no evidence that an ISPA was conducted upon completion of assessments to develop the Change of Status IHCP and to integrate all PNMT recommendations into those plans. The ISP/ISPA documents were not submitted for Individual #542. The PNMT assessment had been completed just prior to the monitoring visit. There were two ISPAs held the week of the monitoring team visit, though neither appeared to be specifically intended to address the PNMT evaluation. PNMT members were present at these, but there was limited participation by the PNMT members, other than the RN, related to the discussion of the recommended cataract surgery.	

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		Plans resulting from PNMT recommendations must address the following components: • Identified PNM needs as presented in the PNMT assessment must be included in the PNMPs, IRRFs, and IHCPs in a timely manner that is consistent with the urgency of need. • Functional and measurable objectives should be outlined to allow the PNMT to measure the individual's progress and efficacy of the IHCPs and PNMPs. • There must be established timeframes for the completion of action steps that adequately reflect the clinical urgency. • The specific clinical indicators of health status to be monitored should be included. • Frequency of monitoring should also be included. <u>PNMT Follow-up and Problem Resolution</u> Each of the recommendations identified in the PNMT assessment should be clearly and consistently tracked through to completion. The format of documentation was improved, though tracking of the status of original recommendations and those required as a function of ongoing review was not always clear. Intervals of PNMT review were clearly stated, and these appeared to occur on a timely basis. A system that addressed implementation of recommendations and other actions should be developed to permit the PNMT (meeting minutes) and others to readily review this information (IPNs). IPNs were consistently entered by the PNMT, but did not always accurately reflect actions taken, outcomes, and dates of completion. Guidelines for these should be developed. <u>Individuals Discharged from the PNMT</u> Discharge was reported for Individual #361, Individual #294, Individual #172, Individual #27, and Individual #351. While there was evidence submitted that stated that each had been discharged from the PNMT, these typically stated the exit criteria and the criteria for re-referral. Only in the case of Individual #361 was a more appropriate discharge summary submitted. There was no evidence of an ISPA meeting conducted to review the course of assessment and intervention by the team and to establish the plan moving forward. There was no evidence of objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP. Further, there was no evidence of ISPA documentation and/or action plan that included clinical indicators to track health status and criteria for referral back to the PNMT (with	

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		the exception of Individual #361, but these were outlined only in the discharge summary and not in an ISPA), particularly if they differed from the criteria included in the PNMT policy. In some cases, for an individual already reviewed by the PNMT, multiple events, such as choking or aspiration, related to the original reason for referral should be addressed before the first reoccurrence, whenever possible. This ensures that the concerns are addressed in a proactive, rather than reactive, manner. As stated in previous reports, an effective PNM program requires that the referral to the PNMT occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is a need for 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, yet this appeared to have become more of a problem in the last six months. Examples of significant concerns identified for individuals during the onsite review suggested that the facility and the PNMT did not fully understand their responsibilities to ensure this. The team is commended for its continued efforts, though continued work related to the timeliness, content, and thoroughness of the documentation of their work is indicated as outlined above. The facility self-rated this provision in noncompliance 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. Ensure that actions taken are adequately documented in the IPNs. 2. A discharge summary should be completed that provides objective clinical data to justify the discharge. This may be via a report or 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 and documented. 3. Ensure that the PNMT assessments address the essential elements outlined above and are completed in a timely manner. Initiation of the assessments should be within five days of referral and completion within 30 days (or no more than 45 in the case of well documented extenuating circumstances). 4. Refine the process of re-referral to be based on clinical indicators rather than only event-based PNM issues.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion with the habilitation therapy director, Danielle Perry, AuD, CCC-A while onsite, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample), because the facility had made limited	Noncompliance

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	and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	progress. The noncompliance finding from the last review stands. <u>Identification of Individuals Requiring a PNMP</u> As described above, at the majority of individuals who required a PNMP were provided with one, with the exceptions outlined above. The Settlement Agreement (in O1, but reviewed here) 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 ISP meeting. Teams are also required to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. For individuals in Samples O.1 and O.2, ISP attendance was reviewed. • In 9 of 13 ISPs, one or more representatives from Habilitation Therapies were present, though sign-in sheets were not submitted for Individual #298 or Individual #151. In five cases, only one discipline was represented and only a COTA was present at one other meeting. There were two representatives at two meetings and all three disciplines were present at the meeting for Individual #521. • In 5 of 13 ISPs, it was noted that sufficient team members were present to adequately review and approve the PNMP, though even in those cases, only one Habilitation Therapy representative was typically present. In the case of Individual #101, the ISP stated that no representative from Habilitation Therapies was present and that the IDT attempted to review and update the PNMP to "best of their abilities." The facility had recently implemented a pre-ISP meeting whereby, three months prior to the ISP, the IDT met to plan for the ISP meeting, including designating who should attend the meeting. The pre-ISP meeting documentation was not submitted for the monitoring team to review whether the appropriate disciplines had been required to attend. Regarding PNMP review: • 8 of 13 PNMPs (62%) were reviewed by the individual's IDT in the annual ISP meeting, though most of these were not thorough or specific, relative to changes required or efficacy. Pages were missing in some cases (e.g., Individual #467) and adequate review by the monitoring team was not possible for some. The most appropriate review was the one completed for Individual #22, though only the COTA was present and the IDT wanted to ensure that an alternative service was provided to address his flexibility. That discussion should have occurred at the ISP, but rather had to be deferred in the form of a request.	

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		• For __ of __ (NA%) individuals in Sample O.1 for whom the IDT identified changes needed to be made to the PNMP, revisions based on the IDT discussion were documented in an ISPA, including rationale, and plan and timeline for implementation. This was not reviewed due to reduced monitoring for this element. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1 and O.2: • PNMPs for 13 of 13 individuals (100%) were current within the last 12 months. • PNMPs for 13 of 13 individuals (100%) included a list of PNM risk levels and individual triggers. • In 13 of 13 PNMPs (100%), there were large and clear photographs with instructions. The copies were submitted were black and white and in many cases were very poor quality. The originals as prepared in color should be reviewed for clarity of detail and it should be ensured that black and white copies were not used for staff reference in any location. • 13 of 13 PNMPs (100%) identified the assistive equipment required by the individual, with rationale or purpose consistently identified for most items. • In 5 of 6 PNMPs (83%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided. Only pictures were provided for Individual #336. In the case of Individual #441, these instructions (PNMP dated 12/18/13) did not match the PNMP change documented by an ISPA dated 10/30/13. Other individuals used a wheelchair for long distances only. • In 13 of 13 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. • In 10 of 13 PNMPs (77%), the type of transfer was clearly described, or the individual was described as independent. In three cases, the transfer for when the individual was unsteady or when cooperative, but alternatives were not outlined (Individual #151, Individual #101, and Individual #185). • In 9 of 13 PNMPs (100%), bathing instructions were provided. In three cases, only positioning was addressed, but not level of assistance required (Individual #22, Individual #101, and Individual #185). In the case of Individual #298, bathing was not addressed at all in the PNMP submitted (1/10/14). • In 13 of 13 (100%) PNMPs, toileting-related instructions were provided, including check and change. • In 3 of 13 (23%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning or was described as independent. • In 13 of 13 PNMPs/dining plans (100%), instructions related to mealtime were	

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		outlined, including for those who received enteral nutrition. • --% of Dining Plans current within the last 12 months. No Dining Plans were submitted. • 7 of 13 individuals had feeding tubes with no oral intake and one other who ate orally. 7 of 7 PNMPs/dining plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. • --% of PNMPs that contained position for meals or enteral nutrition provided via photographs. The pictures were large, but not clear enough to show sufficient detail to assess this metric. • In 6 of 6 PNMPs (100%) for individuals who ate orally, diet orders for food texture were included. • In 4 of 6 PNMPs for individuals who received liquids orally (67%), the liquid consistency was clearly identified. • In 6 of the 6 PNMPs for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular dining utensils. • In 12 of 13 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. Individual #306's listed his medication texture and liquid consistency as "none," though he was on a chopped diet with ground meat. His liquid consistency appeared to be regular and this should be specified in the plan. • In 4 of 13 PNMPs (13%), oral hygiene instructions were included, including general positioning and brushing instructions. Position for toothbrushing was not identified for eight individuals. • 4 of 13 PNMPs (31%) included information related to communication (how individual communicated and how staff should communicate with individual). The others only described how the individual communicated, but no guidelines were outlined as to how staff should communicate with the individual. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> There was evidence that ISPAs had been written related to required changes in the PNMP based on changes in status or identified need. As described in this report, however, the monitoring team was aware that many of these ISPA documents did not represent an actual meeting in which the necessary changes were discussed with plans for implementation. In the case of Individual #298, for example, there was no evidence of review of his PNMP for a change in status (post hospitalization) ISPA on 12/11/13. Diet order changes were listed that included oral intake. The ISPA stated to refer to the PNMP for techniques. Adaptive devices were listed, but there was no review as to efficacy of these or other elements in the plan.	

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		For individuals for whom the PNMP was revised per an ISPA, there was a log that tracked the required change and documented when the changes were made. In the case of Individual #441, there was an ISPA document that indicated that his plan should be changed related to the discontinued use of a pillow to address leaning in his wheelchair. Per the most current PNMP submitted as requested (12/18/13), this change had not been made to his PNMP. The monitoring team concurred with the facility that they were not in substantial 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. Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPAs and changes made to the PNMP within 24 hours or sooner if urgent due to health and safety concerns. The facility should address the issue related to clinicians writing an ISPA document for issues that require discussion. The method to communicate changes that were limited to information exchange only and do not require a meeting should be standardized across clinicians. 2. Documentation of changes to the PNMP should also be more consistently documented in the IPNs to alert all team members that changes were made. 3. Full implementation and review of the pre-ISP process is necessary to ensure that the appropriate IDT members are present for continued review of the PNMP. 4. Address the areas identified above that require improvement.	
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.	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion with the habilitation therapy director, Danielle Perry, AuD, CCC-A while onsite, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample), because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were generally readily available in the dining areas (with a few exceptions in Castle Pines) and PNMPs were included in the individual notebook. General practice guidelines (foundational training) were taught in NEO and in individual-specific training by the therapists, technicians, and PNMPCs. Based on observations conducted by the monitoring team, it was noted that: • 32 of 40+ individuals' (80%) dining plans were implemented as written. The majority of errors were noted in Castle Pines. In this dining area, the Mealtime Coordinator did not understand her role and was not familiar with the dining plans. She personally served food items that were not correct per the prescribed diet orders and instructed staff incorrectly related to a plan. Each of these were	Noncompliance

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		serious infractions that could have potentially resulted in aspiration and/or choking. The dining area and flow of service was disorganized and not conducive to safety. The monitoring team discussed these concerns with the unit director, Rotley Tankersley, the day after these observations at the dinner meal. • 30 of 40+ individuals' (75%) PNMPs related to positioning and mobility were implemented as written, or alignment and support were consistent with generally accepted standards. Based on additional observations: • 1 of 3 (33%) individuals' transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. While transfer steps were completed safely in some cases, the staff did not consistently attend to the individual's position after placement in the wheelchair, particularly when using a mechanical lift. Re-positioning is often necessary after placement to ensure that the individual is aligned properly. Techniques used to accomplish this were not routinely consistent with generally accepted standards. • (NA) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. No bathing was observed during this review, so this metric was not rated. • 1 of 2 (50%) individuals' toothbrushing was implemented appropriately related to safe position and alignment, consistent with generally accepted standards. In Lone Pine, staff in both cases, brushed the individuals' teeth for less than 45 seconds. In one case, the staff only brushed the front teeth and the individual's head was held in hyperextension. She was noted to be at medium risk for aspiration and choking. Todd Miller, the Unit Director, was in attendance for these observations. • 0 of 1 medication administration observation was noted to be consistent with the PNMP. In Woodland Crossing, the nurse put the medication in the individual's (Individual #104) mouth from the medication cup. She then held a paper cup to form a spout and poured the liquid into the individual's open mouth while her head was in hyperextension. The nurse did not use the assistive cup prescribed per the plan. Some additional comments: • Concerns noted related to implementation of PNMPs/Dining Plans were: o mealtime position o pace of presentation o re-positioning techniques o bite size o use of verbal and physical prompts	

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		o correct food texture and liquid consistencies The majority of staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan without coaching from the monitoring team, with the exception of Castle Pines. 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, and reviewed prior to implementation. Staff should have an active knowledge of the individuals to whom they are assigned on any given day: • Staff are 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. • Staff should review plans just prior to implementation of strategies, particularly at mealtime and, as such, information should be fresh on their minds. The facility had implemented Mealtime Coordinator training consistent with the statewide plan, though the process used was not known to the Habilitation Therapy staff. A Mealtime Coordinator was seen in each of the homes, though the staff person in the Castle Pine dining area identified herself as the charge and limited her activities to serving the individuals rather than monitoring implementation of the dining plans. The process used to provide their training and to establish competency was not known to the monitoring team. Standardization of this process and training for staff assigned these duties were essential to ensure adequate competency of these key staff. Unit directors were involved in the implementation and oversight of the program, a particularly exceptional job was done in Lone Pine. The monitoring team concurred with the facility's self-rating that they were not in compliance with this provision. The rate of errors observed continued to be too high in all areas of PNM, though there was clear evidence that the system of Mealtime Coordinator was effective (where it was properly implemented as in one dining room in Lone Pine). The revised training materials related to implementation of the PNMP for direct support staff was excellent and should contribute to further improvements in 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: 1. Fully implement the Mealtime Coordinator system. Review the process for	

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		training these key staff to ensure consistency and to document competency. 2. Ensure there is further focus on transfer and re-positioning techniques to improve staff performance in these areas. 3. The current system used to monitor staff compliance was not adequate. This system must be revised and implemented.	
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.	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion with the habilitation therapy director, Danielle Perry, AuD, CCC-A while onsite, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample), because the facility had made limited progress. The noncompliance finding from the last review stands. <u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time was across two full days with class size limited to 15 new employees to address the PNMP, lifting and transfers, and dining plans and eating skills. The Lifting and Transfers portion of the curriculum was taught by a competency-trained Habilitation Therapy technician as the primary instructor with check-offs of participants conducted by therapists. By report, a content specialist routinely observed this training to ensure consistency and accuracy of instruction. Eating Skills were addressed in another one-day training, again limited to 15 participants. The material was generally taught by an SLP, while the therapy technician reviewed information about assistive equipment. This content included signs and symptoms of aspiration, PNMPs, dining plans, liquid consistencies and food textures. Performance check-offs were conducted by therapists, PNMPCs, and therapy technicians. There were written tests, including pre- and post-tests, administered across each of the three days. Communication was addressed in a four hour time period and is addressed in section R below. The content, based on review of the curriculum materials, was comprehensive. 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. There was no on-the-job training provided at this time. New employees were expected to pass all essential elements of the identified core competencies. The new employee was required to demonstrate competency of foundational skills by safely performing each step, for each foundational skill, without coaching from the evaluator. There was no system to establish competency for staff who provided the training, including the therapy clinicians, PNMPCs, and CTD staff. It did not appear that a formal system to ensure continued competency was in place, however, the therapy clinicians	Noncompliance

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		were reported to routinely sit in on training to address differences in presentation style or content. • Approximately 100% of new employees successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. Staff were retested up to three times, with termination initiated upon the third failure to pass. <u>PNM Core Competencies for Current Staff</u> • 100% of current staff that required training successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs for lifting, transfers, and eating skills through annual refresher training. Staff were re-trained and retested up to three times to ensure continued competence in core skills. In the case, that staff did not pass they were required to repeat the full NEO training and check-offs again. They were not permitted to perform transfers or lifting on the home until they had passed these check-offs. In the case of eating skills, staff were assigned to clerical duties in the training department until they had repeated the class and passed the check-offs before they were permitted to return to duty on their assigned home. In both cases, staff who were not able to demonstrate competency after three trials, were terminated from direct care. • 100% of staff responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. <u>Individual-Specific Training</u> The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. Non-foundational training was conducted on a monthly basis for all new staff in each home for the individuals who lived in that home. All existing staff were trained related to the non-foundational elements of the PNMP and Dining Plan (system of red dots attached to these plans as an alert) prior to the provision of services. Training sheets were maintained in the individual notebooks. Home managers were required to use these training sheets to make assignments for supports provided to specific individuals. While this plan was well intended it appeared that it was not always possible to implement this at this time. It was not clear, however, that all staff had completed competency check-offs in all specialized components of PNMPs (i.e., non-foundational skills) for high–risk individuals prior to the provision of services. All PNMPCs responsible for training other staff successfully completed competency-based training for foundational competencies (core) and the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. The facility had a process to	

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		validate that staff responsible for training other staff were competent to assess other staff's competency. The monitoring team concurred that the facility was not in compliance with this provision. There were a number of implementation/compliance errors related to mealtimes and positioning. It appeared, however, that significant improvement had been accomplished in each of 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. Continue to focus on staff performance through training, coaching, and monitoring. 2. Reinforce the role and responsibilities of the Mealtime Coordinators as well as supervisory staff in identifying and correcting staff performance errors. Further training and monitoring is needed. 3. Refine the system of validating trainers to establish competency as well as to maintain this. This should be clearly outlined in procedural guidelines. 4. Establish safeguards related to the red dot system. Monitoring of compliance with assignments of only trained staff will be essential.	
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.	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	The parties agreed the monitoring team would not monitor this provision because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

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O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion with the director of habilitation therapy, Danielle Perry, AuD, CCC-A, while onsite, the monitoring team agreed to no monitoring because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o LSSLC client list o Admissions list o Staff list o Section P Presentation Book and Self-Assessment o Section O and P QA Reports o Individuals with PNM Needs o Dining Plan Template o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment Tracking Log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to LSSLC: Individual #299, Individual #501, Individual #212, Individual #394, and Individual #55 o OT/PT Assessments, ISPs, and ISPAs for the following individuals: Individual #111, Individual #199, and Individual #504 o OT/PT Assessments, ISPs, and ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #240, Individual #296, Individual #433, Individual #211, Individual #116, Individual #468, Individual #344, Individual #571, and Individual #452. <u>Interviews and Meetings Held</u>: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Kristi Hodges, MS, CCC-SLP o Chris Pedroni, MS, CCC-SLP o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o ISP Meeting for Individual #410 o ISPA for Individual #368

	Facility Self-Assessment: The self-assessment continued to be thorough, though it did not always consistently correlate to all of the elements reviewed by the monitoring team. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The OTPT services department continued to demonstrate hard work and a focus on accomplishing their established goals. The facility initially requested full monitoring for section P1, P2, and P3, with no monitoring for P4. Based on interviews throughout the week of this onsite review with the habilitation therapies director, the monitoring team agreed to conduct reduced monitoring only for these elements, and no monitoring of P4. This was done by summarizing the facility's activities and reviewing the facility's status with a small sample. As such, all areas were found to be in noncompliance by the facility and, while the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these self-ratings.
	Summary of Monitor's Assessment: There was continued, but limited progress toward substantial compliance in all aspects of provision P. Efforts to improve the content of assessments were noted via audits, but only one was reviewed and it was lacking 57% of the required elements. While on-time completion had continued to be problematic for most of this review period, there had been a notable improvement since December 2013, with 100% reported to be submitted on or before the established due date. There were few intervention plans with few SAPs in place for individuals with OT/PT needs and those reviewed were not well documented with an assessment and discharge summaries. A significant concern about falls was noted by the monitoring team throughout the onsite review and is related to this section of the Settlement Agreement. As discussed throughout the onsite week, the IDTs need to be more responsive to the incidence of falls. Equally important was the need to establish an approach to fall prevention. There were failures to evaluate all environments and make improvements to hazards that may contribute to falls (e.g., condition of sidewalks). In a specific example, Individual #368 who was blind in his left eye, was recommended for cataract surgery for his right eye (in which he had no or very limited vision), yet until there had been no evidence of IDT members advocating to pursue this procedure, even though he had at least 65 falls in the last year and nine in the month of the onsite review. Three occurred in one day during the week of the review. During the onsite week, the IDT determined that the surgery was important, obtained consent, and the procedure was scheduled for 2/6/14. OTs and PTs are key members of the IDT. They should be notified of all ISPA meetings in a timely and consistent manner and attend as indicated. When in attendance the clinicians each have an important responsibility to:

	• Think creatively and cooperatively to identify problems and needs; • Work with others to identify solutions; • Be a part of making things happen in a timely manner; • Recognize the urgency of health and safety; and • To respect and ensure each individual's right to independence and quality of life by speaking up and serving as an active advocate on their behalf. Samples for Section P: • Sample P.1: 3 individuals for whom the best and most current OT/PT/SLP assessment was selected by the clinicians and submitted with ISPs and ISPAs. • Sample P.2: 5 individuals newly admitted in the last six months for whom a current assessment was submitted. • Sample P.3: 9 individuals who were provided direct OT and/or PT services per the list submitted.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion during the onsite review week with the habilitation therapies director, Danielle Perry, AuD, CCC-A, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample) because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Assessments</u> One of the best and the most current assessments selected by each OT and PT clinician were requested for review based on proposed reduced monitoring for this element. Only one assessment was submitted, though packets of information (ISPs, ISPAs, and progress notes) were submitted for two others. It was presumed by the monitoring team that these were not contained in the individual records. OT/PT assessments (Sample P1) were submitted as follows (dates listed are the therapist signature dates): • OT/PT/ST Comprehensive Evaluation 1. Individual #111 (11/19/13) This assessment was completed by Cristen Nerren, PT, DPT, and Stacy Kadrmas, OTR. The other packets included information for Individual #199 (Willy Reyes, PT, and Ann Musto, OTR), and Individual #504 (Gail Harris, PT, and Laura Kunstmann, OTR). Because the assessments were not submitted, they could not be used for the analysis of content below. <u>Timeliness of Assessments</u> Eight individuals were admitted to LSSLC since the last review. A Comprehensive Evaluation was submitted for five of these (Individual #299**,** Individual #501, Individual	Noncompliance

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		#212, Individual #394**,** and Individual #55). • 4 of 5 individuals in Sample P.2 (80%) received an OT/PT assessment within 30 days of admission based on the Admission Activity list and the signature dates on the assessment. This was an improvement from 60% in the previous review. The assessment for Individual #394 did not contain dated signatures, so it was not known if these were completed in a timely manner. The following metric was not applied because, as LSSLC did not utilize a new admission screening at the time of this review: • For individuals identified with therapy needs through a screening, --% received a comprehensive OT/PT assessment within 30 days of identification. Based on review of the single evaluation submitted: • 1 of 1 individuals' OT/PT assessments (100%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 8% in the previous review, though finding is skewed due to the sample size of one. There were 224 assessments listed in the facility's tracking log for ISPs, dated 7/1/13 through 2/27/13. Based on this log, 50% of the assessments were performed on, or prior to, the designated due date, though since 11/29/13 (for ISPs since 12/13/13), 100% were listed as completed on time. By report, this was determined by the date the assessment was entered into the data file. This was an improvement from 19% in the previous review. • 1 of 1 assessment (100%) was current within 12 months for individuals in Sample P1. <u>OT/PT Assessment</u> Only one Comprehensive Evaluation from Sample P1, as described above, was included in the following analysis. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The assessment format and content guidelines generally required that these elements be in the assessments. The analysis for comprehensiveness of the OT/PT/SLP assessment was as follows, though comparison findings to the previous review were skewed due to the current sample of one (and thus omitted): • 0 of 1 assessment (0%) was signed and dated by the clinician upon completion of the written report. Only one of the three clinicians had dated this evaluation. • 1 of 1 assessment (100%) included medical diagnoses. • 0 of 1 assessment (0%) included medical history. • 0 of 1 assessment (0%) documented analysis of the impact of diagnoses and	

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		relevance of medical history to functional status. This was done in a generic manner, rather than specifically as it related to Individual #111. • 0 of 1 assessment (0%) addressed health status over the last year. There was a review of progress notes that identified issues specific to OT, PT or ST, but issues related to the status of his general health over the last year was not reported. • 0 of 1 assessment (0%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. • 0 of 1 assessment (0%) included a section that reported health risk levels that were associated with PNM supports. Only risks related to choking, aspiration, and falls were reported though he had diagnoses related to cardiac, dental, and osteoporosis, for example, that were also PNM-related. • 1 of 1 assessment (100%) listed medications and potential side effects relevant to functional status. • 1 of 1 assessment (100%) included individual preferences, strengths, and needs. • 1 of 1 assessment (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work), though this appeared related only to a mealtime observation. • 1 of 1 assessment (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. • Individual #111 required a wheelchair (transport) for long distances only, so the description was limited. • 0 of 1 assessment (0%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. No findings from effectiveness or compliance monitoring were reported. 0 of 1 individual's OT/PT assessments (0%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • 1 of 1 assessment (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP that addressed the individual's PNM risk levels. This only related, however, to three risk areas despite that Individual #111 was at risk in additional areas that were PNM-related. The clinicians determined that his PNMP had been "somewhat effective" in that he only had two falls within the last year. It was not known if this was an improvement from previous rate of falls. They reported that the falls were due to environmental hazards, yet did not describe any interventions in place to address this. This is a new metric since the previous review. • 0 of 1 assessment (0%) included discussion of the individual's potential to develop new functional skills. Though he was described with the potential to learn new functional tasks or expand current ones, there was no rationale offered	

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		and no indication that this was recommended. • 0 of 1 assessment (0%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct OT/PT interventions and/or skill acquisition programs as indicated for individuals with identified needs. There was no rationale given for not requiring direct OT/PT intervention and only changes in the PNMP were described as indirect supports. • 0 of 1 assessment (0%) included a monitoring schedule. • 0 of 1 assessment (0%) included a re-assessment schedule. While future assessments were mentioned, it was stated that this would be done annually as needed per referral or change in status. As such, it was not clear when he would receive a subsequent assessment. An individual with identified needs should have an annual assessment or sooner if needed based on a change in status. • 1 of 1 assessment (100%) made a determination about the appropriateness of transition to a more integrated setting. • 1 of 1 assessment (100%) detailed the supports and services needed for successful community living, though this was very limited. • 1 of 1 assessment (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. The Assessment of Current Status was considered an update to the previous Comprehensive Assessment. In that case, the existing Comprehensive Assessment should be available in the individual record along with each subsequent Assessment of Current Status, until such time that the comprehensive was repeated (i.e., in three years, or other established interval per policy or assessment recommendation). At that time, each would be purged and replaced by the new Comprehensive Assessment and the cycle would be repeated. There were new assessment formats recently developed by the state and distributed. These contained standardized main headings were to be used by all disciplines. The facility was in the process of implementing these changes. The following metric should be considered in the implementation of the Assessment of Current Status as it is standardized at LSSLC. • For --% individuals for whom Updates/Assessments of Current Status were completed, the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data from the previous year and monitoring and re-assessment schedules. Further findings revealed continued improvements related to OT/PT assessments as follows:	

#	Provision	Assessment of Status	Compliance
		• The compliance of this assessment with the elements listed above was approximately 43%. There was an audit system in place involving self-assessments, audits by the director and the outside consultant. This would be an appropriate approach at such time as all clinicians have demonstrated competency with the elements identified above. There was a reported improvement of on-time assessments submitted since 11/29/13 of 100% submitted on or prior to the due date of 10 days prior to the ISP. To continue 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 that assessments are completed by the due dates (10 days prior to ISP). 2. Ensure that the audit system promotes improvements in the content of OT/PT assessments at or near 90%. Consider setting benchmarks for the department as a whole as well as for individual therapists in order to achieve this. 3. Clarify the function and format of the Assessment of Current Status. 4. Ensure that completed assessments are filed in the individual records. 5. Consider contacting other facilities who have been found in compliance with this provision to identify additional strategies to ensure continued progress.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion during the onsite review week with the habilitation therapies director, Danielle Perry, AuD, CCC-A, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample) because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Direct OT/PT Interventions:</u> There were 29 individuals listed as participating in direct OT and/or PT and nine of these were included for review in Sample P.3 as follows (Individual #571, Individual #240, Individual #116, Individual #468, Individual #344, Individual #296, Individual #452, Individual #211, and Individual #433). • For 8 of 9 individuals (89%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale. All individuals in the Sample P3 were provided an annual assessment or interim consult except Individual #571 (see below). For the others, while assessments were completed and documentation was noted, a number of these were vague and did not clearly establish a baseline for therapeutic intervention (Individual #116, see below). Per an ISPA on 9/26/13 for Individual #240, the IDT had requested a fine motor evaluation. There was no evidence that this had been completed in the documentation	Noncompliance

#	Provision	Assessment of Status	Compliance
	and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	submitted. o Individual #571: There were progress notes related to a safety assessment for her related to wheelchair mobility, but the content did not sufficiently document findings related to her potential to learn or to navigate with assistance and supervision. Rather, it was determined that she was unsafe for wheelchair mobility in her current home environment, but there were no recommendations related to direct intervention and training to address this. o Individual #116: Her assessment was based on the Sensory Integration Inventory, Revised. The clinician reported that Individual #116 demonstrated seeking-behavior for more vestibular input, but described that when she was over-stimulated, she displayed rocking and swaying. The frequency of this was not reported, however. The goals were related to her not "ballistically rocking" for 30 minutes at a time, with strategies outlined to promote calming (brushing, deep pressure weighted strategies), as well as a variety of vestibular and proprioceptive activities. There was no baseline established for rocking of this nature and the goal was not measurable in the sense that she could accomplish this goal in one 30-minute time period on one occasion. • 8 of 9 individuals had direct intervention plans (89%) implemented within 30 days of creation, or sooner, as indicated by the individual's health and safety. Despite being listed as provided direct therapy, there was no actual intervention provided to Individual #571 because she was determined to be unsafe for powered mobility via a brief assessment. As stated above, no therapeutic intervention or training was recommended to address this. • For 0 of 9 individuals (0%), there were objectives related to functional individual outcomes included in the ISP or ISPA. o Individual #116: For example, the goals as described above were not measurable, were not functional (the focus was for her to not demonstrate a behavior for 30 minutes, rather than to demonstrate a functional behavior, such as sit quietly for 30 minutes while engaged in a particular activity), and were not in the ISP or ISPA. Two additional objectives addressed a goal for staff training rather than Individual #116 and the other stated that she would participate in a brushing program. As stated above, the brushing program was not clearly justified per the assessment and was not well outlined. Again neither of these objectives was measurable or functional for Individual #116. • For 0 of 8 individual's record (0%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Individual #468 continued in direct therapy at the time of this review so a discharge summary was not indicated. There were no adequate	

#	Provision	Assessment of Status	Compliance
		discharge summaries for the other seven individuals who appeared to no longer participate in direct therapy intervention per the documentation reviewed by the monitoring team. Some examples included: o Individual #116: She was discharged per a brief progress note on the therapy plan in August 2013. This note was not dated and was a weak summation of intervention. One measure used for discharge was that she sat for two hours during a movie without rocking on one occasion, though there had not been any baseline established during the assessment to determine if this was significant. The objectives were related to participation in a brushing program that was not outlined as to strategies used and frequency. Therapy frequency was identified as up to 15 times per month, yet since the evaluation on 6/18/13, she was seen for intervention only three times in June 2013, 12 times in July 2013, and eight times in August 2013, which included staff training. o Individual #433: She was reported to be discharged from therapy because the physician's order had not been signed and that due to the holidays, weather and illnesses, it was recommended that therapy resume after the holidays. There was no indication that therapy had resumed at the time of this review. As such, the justification for discharge was inadequate. The system for documentation was inconsistent for each of the individuals reviewed. The rationale and intervention plan was outlined with measurable and functional objectives noted in some cases. Some of the documentation submitted was on a therapy progress note/individual program plan form while some was noted in the IPNs. <u>Progress notes/IPNs:</u> • For 9 of 9 individuals receiving direct OT/PT Services (100%) there were progress notes (IPNs) at least monthly, with most documenting each therapy session in some manner. Monthly notes were written in some cases. Most of the documentation did not contain each of the indicators listed below, however: o 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); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.	

#	Provision	Assessment of Status	Compliance
		Indirect OT/PT Interventions: The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format, content and integration into the ISP and section S for skill acquisition plans. Implementation of PNMPs is addressed in section O.5. Integration of OT/PT Interventions, Supports and Services in the ISP Review of the PNMP and Dining Plans are required by the IDT at least annually during the ISP meeting. This requires that key team members be present, including the OT and/or PT clinicians. The current system required that the IDT designate which team members were required to attend the ISP during the pre-ISP meeting. Review of the ISPs for Sample P.1 (all three individuals were included as ISPs were submitted for each) was as follows: • 100% (3 of 3) of the ISPs submitted were current within the last 12 months. • 100% (3 of 3) of the current ISPs had attached signature sheets. • 0% (0 of 3) of the current ISPs with signature pages submitted was attended by both the OT and PT. • 0% (0 of 3) was attended by PT only. • 33% (1 of 3) was attended by OT only. • 67% (2 of 3) of the current ISPs had no representation by an OT or PT and no assessment had been completed at the time of the ISP. Per the tracking log, the assessment for Individual #199 was completed on 11/20/13, the day before her ISP. No assessment findings were reported in the ISP or subsequent ISPA with no OT/PT representation at the meeting. The ISP for Individual #504, was dated 1/24/13 (the ISP for the previous year) and was expiring at the end of the month of this onsite review, though no OT or PT had attended that meeting. All assessments for the upcoming ISP would have been due at this time. Per the tracking log, his OT/PT assessment had been completed on-time (on or prior to 1/9/14). The IDT needs to clearly establish a rationale for attendance by each team members via the pre-ISP meeting and, once established, attendance should be consistent with this rationale. Clinicians may find the need to negotiate their attendance based on actual services and supports provided and/or proposed to be provided at the time of the pre-ISP. This element was self-rated to be in noncompliance and the monitoring team concurred with the self-assessment. To continue 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:	

#	Provision	Assessment of Status	Compliance
		1. Rationale in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 2. Representation by OT and/or PT should be reconciled with the IDT during the pre-ISP process and should be consistent with the designation by the team. 3. Ensure that there is an assessment or consult that clearly establishes the need for OT/PT interventions and that states the goals and objectives. 4. Ensure that there is a clear discharge summary (in the IPNs). 5. OT and PT supports must clearly be outlined in the ISP. In the case that interventions are initiated outside the scheduled annual ISP, an ISPA must document initiation of the service, report progress and termination with rationale.	
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.	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion during the onsite review week with the habilitation therapies director, Danielle Perry, AuD, CCC-A, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample) because the facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	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, revised 8/19/13 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 Annual Dental Assessments for the following individuals: • Individual #572 Individual #551Individual #59, Individual #518, Individual #31, Individual #385 Individual #122 Individual #9 Individual #139, Individual, #418 o Annual Dental Summaries for the following individuals: • Individual #184, Individual #560, Individual #187, Individual #480, Individual #352, Individual #27, Individual #413, Individual #238, Individual #213, Individual #521, Individual #532, Individual #111, Individual #158, Individual #568, Individual #385, Individual #45 o Oral Surgery Consultations for the following individuals: • Individual #160, Individual #267, Individual #594 Individual #182, Individual #144, Individual #178, Individual #220, Individual #51 Interviews and Meetings Held: o Ahmad Jafri, DDS, Dental Director o Tina Murray, DDS, Facility Dentist o JoAnne Lancaster, RDH o Frances Tucker, RDH o Evelyn Barnes, Dental Assistant o Nancy DeVore, Dental Clerk Observations Conducted: o Dental Clinic o Dental Clinic Observation of treatment o Informal observation of oral hygiene regimens in residences

	o Pretreatment Sedation 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. The dental director described, for both provision items, a series of activities engaged in to conduct the self-assessment. The self-assessment was completed using a state issued template that had been used for the past several reviews. Overall, it reflected the major items reviewed by the monitoring team. The facility rated itself in substantial compliance for provision Q1 and noncompliance for provision Q2. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: Continued progress was seen in the provision of dental services. There were no staffing changes since the previous compliance review. The required assessments were completed in a timely manner and most individuals were seen at least twice a year in clinic. The documentation of the assessments that were completed improved significantly. The state dental database was implemented in November 2013 and a standardized Annual Dental Summary was now utilized. The documentation of annual examinations was also standardized and the new format included an adequate amount of information. Odontograms were completed as part of the Annual Dental Summary. These changes resulted in improvement in the information that was available to the IDTs regarding the status of the individuals' oral health. The number of individuals with poor hygiene ratings decreased, but improvement was still needed. The suction toothbrushing program was expanded, but lacked adequate involvement of the dental clinic. Records indicated that radiographs were being taken, but this was another area where improvement was necessary. A new process for review of pretreatment sedation was implemented. This process required that clinicians meet to discuss risk, benefits, and the options available. TIVA continued to be performed two days each month. Records indicated that protocols were in place for monitoring individuals. There were no medical or dental policies in place that broadly addressed the use of sedation and anesthesia, such as the level of sedation that was permissible in the facility and the selection of individuals. Refusals and problems related to poor oral hygiene were being addressed through collaborative efforts of the behavioral health, habilitation therapy, and dental departments. The impact of this new system will be assessed during future reviews.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.</td><td>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 and dental director.

<u>Staffing</u>
The dental clinic staff was comprised of a full time dental director, part time dentist, full time hygienist, two part time hygienists, a part time dental clerk, and a full time dental assistant. The dental director worked Monday through Thursday. The part time dentist worked Monday through Friday mornings for a total of 20 hours each week.

<u>Annual Assessments</u>

<table>
<tr><td colspan="7">Annual Assessment Compliance 2013</td></tr>
<tr><td></td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td></tr>
<tr><td>No. of Exams Completed</td><td>31</td><td>35</td><td>32</td><td>24</td><td>36</td><td>19</td></tr>
<tr><td>% Timely Completion</td><td>90</td><td>94</td><td>84</td><td>92</td><td>72</td><td>95</td></tr>
</table>

The monitoring team requested a list of annual assessments completed in the last six months, listed by month. The facility submitted a list of assessments based on a list for ISP meeting dates. In doing this, the list included assessments that were not completed during that month. For example, the listing for the ISPs for the month of June 2013 included the assessments done in March 2013. This increased the total number of exams for a specified time period thereby changing the overall compliance rate. While the self-assessment found a compliance of 93% completed within 365 days, the monitoring team used the data provided and found a compliance rate of 88%. The list also included several exams that had "T" included with the date. There was no ledger with the list that provided explanations for delinquent exams. For future reviews, the facility should provide the list of annual exams performed during each month along with the date of the previous assessment.

Ten Annual Dental Examinations were submitted as part of the complete records. The facility utilized a single template for all examinations. It included information on level of cooperation, oral hygiene rating, plaque level, calculus level, bleeding level, mobility grade, periodontal disease/gingivitis (measured in mm), oral cancer exam, missing teeth, presence of decay, radiographic findings, and behavior. It also included recommendations, treatment rendered, sedation used, and indicated if oral hygiene instructions (OHI) were provided. A risk rating was also documented. This information was included in the 10 Annual Dental Examinations reviewed. Overall, the dental examinations were thorough and complete. Even so, there were a few aspects of the assessments that should be addressed:</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		• The documents did not include information on positioning. • While it was documented that OHI were given, the evaluations provided little commentary of specific measures that were to be taken. • Treatment recommendations usually stated prophylaxis as scheduled. • It was difficult to determine if the risk ratings were based on the criteria used in the IRRF. • The date of the last radiographs could not be determined if not done as part of the current examination. The Annual Dental Summaries were completed at the time that the annual examinations were done. A state issued template was utilized. This summary included information on current oral hygiene, tissue status, and use of sedation. It also documented periodontal condition and each assessment included an odontogram. The use of the odontogram key required a color copy for interpretation. A separate statement included the numbers for missing teeth and those with restorations. Comments related to preferences, strengths, goals, and community living and services were also included. Copies of 17 Annual Dental Summaries were submitted for review. The following summarizes the data included in those documents: • 17 of 17 (100%) had an entry concerning behavioral issues, and the need for sedation/restraint use • 17 of 17 (100%) documented oral hygiene status • 17 of 17 (100%) had entries related to periodontal status o 4 of 17 (24%) individuals were edentulous • 17 of 17 (100%) documented oral cavity tissues • 17 of 17 (100%) included a completed odontogram • 17 of 17 (100%) documented treatment recommendations • 17 of 17 (100%) documented risk ratings specific to periodontal disease and caries • 17 of 17 (100%) included comment on community and living services • 0 of 17 (0%) included comments on preferences, strengths, and goals. <u>Initial Exams</u> Seven individuals were admitted during the reporting period. All completed initial evaluations within 30 days. <u>Oral Hygiene</u> The facility continued to monitor the oral hygiene ratings of the individuals. The following data were reported:	

#	Provision	Assessment of Status	Compliance

Oral Hygiene Ratings 2013- Annual Exams (%)		
	Jun - Aug	Sep - Nov
Good	45%	59%
Fair	40%	32%
Poor	16%	9%

These ratings were based on the hygiene status observed during the annual examinations. Based on these data, the oral hygiene status of individuals was improving.

The facility also presented data based on a total of all clinic appointments. These data are presented in the table below.

Oral Hygiene Ratings 2013 – Clinic Visits			
	Mar - May	Jun - Aug	Sep - Nov
Good	39%	47%	46%
Fair	41%	34%	39%
Poor	19%	19%	14%

The average ratings for the reporting period June 2013 through November 2013, based on 650 clinic visits, were 44% good, 38% fair, and 17% poor. These data indicated that overall hygiene ratings in the facility were improving. The dental director reported that when individuals had poor oral hygiene due to behavioral issues, written documentation was forwarded to psychology requesting assistance. Habilitation Therapy was also requested to provide input to determine barriers to dental treatment. Individuals were given three-month recall appointments. When fair oral hygiene was observed, OHI were provided to the individual and/or staff during the clinic appointment or as part of the Dental Outreach Program. These individuals were assigned a four-month recall appointment. Individuals with good oral hygiene were seen at six-month intervals. The facility did not provide data on the percentage of poor ratings that were attributed to behavior.

<u>Dental Outreach Program</u>
As noted in the previous monitoring team report, 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. Assessments were completed, treatment provided, and staff training was conducted. The program was temporarily suspended at the time of the compliance review due to home flu restrictions.

<u>Suction Toothbrushing</u>
Seventy-six individuals received suction toothbrushing. Individuals were identified by

#	Provision	Assessment of Status	Compliance
		their primary care providers who prescribed the treatments. The program was coordinated through the medical department. Dental hygienists and nursing staff provided training to direct support professionals and nursing during employee orientation. Home managers were trained and provided additional training for direct support professionals. Home managers also provided supervision to ensure that this treatment occurred. It appeared that the dental department was not actively involved in this process. There were no data presented to document compliance with treatment or the effectiveness of the treatment. The monitoring team encountered discussions in the daily clinical morning meetings and infection control minutes related to noncompliance and other problems related to the provision of this treatment. To maintain substantial compliance, the dental department will need to have greater involvement and oversight in this process. There will need to be documentation that this treatment is occurring as prescribed and whether it is effective. <u>Preventive, Restorative, and Emergency Services</u> The dental clinic provided the breadth of services required to care for the individuals at LSSLC. The dental clinic provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, extractions of non-restorable teeth, endodontic treatment, and x-rays. The facility maintained a contract with a board certified dental anesthesiologist who provided services two days each month. Individuals who required treatment that was more extensive were referred to a local oral surgeon. Data related to the provision of services were tracked in the state issued dental database which was implemented on 11/1/13. The total number of clinic visits and key category visits are summarized below. Dental Clinic Appointments 2013 | | Jun | Jul | Aug | Sep | Oct | Nov | | Preventive | 60 | 113 | 43 | 83 | 87 | 28 | | Emergency | 1 | 0 | 0 | 0 | 0 | 0 | | Extractions | 3 | 0 | 5 | 7 | 2 | 2 | | Ext (Off-Campus) | 0 | 0 | 0 | 2 | 1 | 0 | | Restorative | 4 | 1 | 2 | 1 | 6 | 2 | | Total Appointments | 123 | 176 | 87 | 147 | 124 | 58 | Nineteen individuals had teeth extracted at LSSLC, while three individuals had extractions done by the oral surgeon. Individuals who required full mouth extractions and those individuals that were more medically fragile were referred to the oral surgeon.	

#	Provision	Assessment of Status	Compliance
		Emergency care was available during normal business hours. After business hours, the on-call physician was contacted and made a determination about the need for urgent dental care. The dental director was available by phone to discuss care with the primary providers. <u>Radiographs</u> The monitoring team discussed the requirement for radiographs with the dental director. Generally, a full mouth set of radiographs was completed every two years for individuals at risk. Individuals not at risk had x-rays completed every three years. This was consistent with the general ADA guidelines. The facility reported that using the standard of requiring x-rays every two years, 179 individuals or 52% of the average census for the monitoring period, had current radiographs. For the 10 Annual Dental Assessments listed in the documents reviewed, six individuals had x-rays completed in 2013, two in 2009, one in 2010, and one in 2011. Overall, 70% of the sample had x-rays within two years. The facility reported that for many individuals, x-rays could only be obtained under general anesthesia. The dental director reported that he was working with the facility director on getting this done. The facility might also discuss this with the state office dental services coordinator. In order to maintain substantial compliance, the facility will need to show that there was a plan to increase this percentage and that the plan was implemented. Further, the facility should include requirements for radiographs in current policy. <u>Oral Surgery</u> Eight individuals were referred to the oral surgeon for treatment. The consults for those individuals were reviewed. Most individuals were referred for multiple extractions or whole mouth extractions. One individual had a single extraction with the use of general anesthesia. Two delays were noted. Individual #160 was referred on 1/16/13 and had a consultation on 6/27/13. Treatment was completed on 10/15/13. Individual #594 was referred on 4/29/13, consultation was completed on 6/27/13, and treatment completed on 12/2/13. <u>Sedation/General Anesthesia/TIVA</u> The facility continued to utilize oral sedation and TIVA to facilitate dental treatment. 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. A pretreatment sedation consultation procedure was implemented to require a collaborative approach between the clinical disciplines involved in the process. A	

#	Provision	Assessment of Status	Compliance
		meeting was conducted on Tuesdays and Thursdays to discuss the most appropriate medications, risks, and benefits. Side effects of medications were reviewed and potential TIVA medications were included as part of the review. Participants included the primary providers, dental director, psychiatrist, clinical pharmacist, QIDP coordinator, and medical compliance coordinator. A consensus regarding the plan was agreed upon by the clinicians. The dental director reported that he received certification in Level I oral conscious sedation in September 2013. The facility continued to track the use of oral sedation and TIVA. Those data are summarized below.	

General Anesthesia/Minimal Sedation						
	Jun	Jul	Aug	Sep	Oct	Nov
TIVA	7	0	8	7	7	8
Oral Sedation	4	3	1	3	4	0
Off Campus	0	0	0	2	1	0
Total	11	3	9	12	12	8
Total Appointments	123	176	87	147	124	58

Individuals were recovered in the dental clinic. Nursing policy required that the anesthesiologist document that the level of consciousness, oxygenation, ventilation, and circulation were adequate prior to discharge from the dental clinic. Protocols for monitoring in the infirmary were followed. An RN was assigned to provide care to individuals in the infirmary following recovery.

The records for six individuals were reviewed and indicated that monitoring protocols were followed. Two of the six individuals were admitted to the infirmary due to complications following TIVA. A third individual was noted to be lethargic for several days following TIVA. On post-op day five, a direct support professional noted that the individual had a "black eye." No additional information was available regarding the cause of the injury.

The medical and dental departments did not have a specific policy that outlined the scope of sedation that could be utilized at the facility and the process for determining candidates for these services. On the other hand, much of this was covered through a variety of policy and procedures at the facility (e.g., nursing policies, pretreatment sedation policy).

The facility had several nursing policies related to monitoring when sedation and anesthesia were utilized. The dental services policies included a section on the use of sedation, which referenced the use of intramuscular medications for sedation (not associated with TIVA). During the compliance review, the discussion of conscious

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		sedation surfaced and the monitoring team understood that LSSLC only utilized oral medications for pretreatment sedation. The monitoring team strongly recommends that the state dental and medical services coordinators draft comprehensive policies and procedures that specify: 1. Scope of services provided, such as level of sedation permissible, use of TIVA, use of only minimal sedation and TIVA) 2. Indications for use of anesthesia 3. Who are candidates for TIVA 4. Who are candidates for referral to hospital for treatment 5. Criteria for TIVA implementation, such as board certified anesthesiologist, ACLS certification, etc. 6. Evaluation of individuals prior to anesthesia 7. Post-anesthesia monitoring of individuals. As part of it's quality efforts, the dental clinic should also track and document adverse events that occur following sedation and TIVA, such as individuals who require admission to the infirmary or transfer to acute care facilities within 72 hours of procedures. <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 dental outreach program. Additionally, all direct support professionals were required to complete the Oral Care refresher course annually through iLearn. The facility reported that 99% of direct support professionals were current with regards to the refresher training. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. Even so, there are some issues that require attention for this entire provision to maintain substantial compliance. The monitoring team, therefore, makes the following recommendations: 1. Efforts should be directed towards increasing the percentage of individuals with current radiographs. The annual assessment should clearly note the dates of the most recent radiographs. 2. Address the bulleted suggestions regarding the annual assessments, including better documentation of the types of OHI that are being provided to individuals	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>and/or staff.
3. The oversight of the suction toothbrushing program should be reviewed as documented above.
4. The facility should address concerns related to TIVA as noted above, including the development of specific policy.</td><td></td></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td><u>Policies and Procedures</u>
The monitoring team requested all facility (local) policies related to the provision of dental care. The dental department submitted the dental services manual which covered 24 areas related to the provision of dental services, including important topics, such as general operations of the clinic, staffing, informed consent, sedation, oral care, infection control and training. As noted in section Q1, additional guidance was needed relative to policy for the use of sedation/TIVA. Guidance for completion of radiographs should also be included in this manual. Overall, the department had developed a very thorough set of policies, procedures, and guidelines to explain the functions of the department and the steps necessary to carry out those functions.

<u>Dental Records</u>
Dental records consisted of IPN entries, Annual Dental Examinations, Annual Dental Summary, and odontograms. Improvements were noted in the dental documentation. The annual examination records were more comprehensive and provided the required information. As noted in section Q1, improvement was needed in the documentation of the treatment plans. More information should be documented on the specific oral hygiene instructions that are being provided to staff and individuals. Most of the documents reviewed only stated assistance was needed with toothbrushing.

<u>Failed Appointments</u>
The guidelines issued by state office required reporting of <u>missed/no show</u> appointments and <u>refusals</u>. A missed appointment was one that was not attended by the individual because of reasons beyond his or her control. Refusals were appointments not attended because the individual stated he or she did not want to go. The failed appointments were the total number of missed appointments and refusals. The numbers as identified and reported by LSSLC are summarized in the table below:

<table>
<tr><td colspan="7">Failed Clinic Appointments 2013</td></tr>
<tr><td></td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td></tr>
<tr><td>Missed/No show</td><td>2</td><td>2</td><td>1</td><td>5</td><td>3</td><td>0</td></tr>
<tr><td>Refused</td><td>15</td><td>11</td><td>0</td><td>17</td><td>10</td><td>2</td></tr>
<tr><td>Failed</td><td>17</td><td>13</td><td>1</td><td>22</td><td>13</td><td>2</td></tr>
<tr><td>% Failed</td><td>14</td><td>7</td><td>1</td><td>15</td><td>10</td><td>3</td></tr>
<tr><td>Total Appointments</td><td>123</td><td>176</td><td>87</td><td>147</td><td>124</td><td>58</td></tr>
</table></td><td>Noncompliance</td></tr>
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		For the 13 missed appointments reported from June 2013 through November 2013: • 8 of 13 (61%) were due to hospitalization • 3 of 13 (23%) were due to illness • 1 of 13 (7%) was due to home visits • 1 of 13 (7%) was due to school Overall, the number of missed appointments was very small. When appointments were missed, they were usually re-scheduled and completed without significant delay. The failure rate for the reporting period (excluding November 2013 data) was 9%, and most of the missed appointments were attributed to illness. This was an improvement from the failure rates of 20% and 28% reported for the last two compliance reviews. 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. <u>Sedation and Dental Restraints</u> The facility documented that for the reporting period 10.8% of the average census used general anesthesia and 4.4% required sedation. The use of both modalities required the approval of the Human Rights Committee. The approval was obtained for all individuals. The dental department did not utilize mechanical restraints. <u>Strategies to Overcome Barriers to Dental Treatment</u> The refusal rate for the reporting period was period was 7.6%. Behavioral health services was in the process of developing a new approach for working directly with the dental department. The dental clinic sent notification to behavioral health when an individual was assessed with poor hygiene or refused treatment. A request was made for behavioral health and/or habilitation therapy to attend the next scheduled clinic appointment. This was a relatively new process, but the clinic staff believed it had the potential to be effective. They provided one example of early success such as Individual #485 who, by attending an appointment and sitting in the dental chair, demonstrated progress. The Dental Outreach Program also provided informal desensitization by allowing the dentist to provide assessments and some treatment in the individual's home environment. That program was suspended at the time of the compliance review due to home restrictions related to infection control. The facility was planning to utilize the Integrated Health Care Plans to document recommendations to improve oral care. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in	

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		the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The dental director should address the need to add additional topics to the dental manual. 2. The facility will need to continue to address the problem of refusals and document the outcomes of the new systems that have been implemented.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o 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 List of individual with PBSPs 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 Behavior Support Committee attendance database 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 Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: • Individual #535, Individual #294, and Individual #333 o Communication Assessments, ISPs and ISPAs for the following individuals: • Individual #308, Individual #20, and Individual #410 Interviews and Meetings Held: o Danielle Perry, AuD, CCC-A, Habilitation Therapies Director o Kristi Hodges, MS, CCC-SLP o Chris Pedroni, MS, CCC-SLP o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day programs o ISP Meeting for Individual #410

	Facility Self-Assessment: The self-assessment continued to be thorough, though it did not always consistently correlate to all of the elements reviewed by the monitoring team. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The communication services department continued to demonstrate hard work and a focus on accomplishing their established goals. The facility initially requested full monitoring for section R1, R2, and R3, with no monitoring for R4. Based on interviews throughout the week of this onsite review with the Habilitation Therapies Director, the monitoring team agreed to conduct full monitoring only for R1, reduced monitoring for R2 and R3, and no monitoring of R4. As a result, the monitoring team received summaries of activities from the facility and reviewed the status with a small sample only. As such, all four provisions were self-rated to be in noncompliance by the facility and, 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, but limited progress toward substantial compliance in all aspects of provision R. Efforts to improve the content of communication assessments were noted. Though there were some improvements in assessment content for those assessments completed, the provision of assessments for individuals at the time of their ISP continued to be problematic. The facility had decided to focus on those individuals identified as Priority 1 (approximately 122 individuals who were nonverbal and with behavioral concerns) for the next six-month period. There were relatively few communication plans and SAPs in place for individuals with communication needs and for those with behavioral concerns and severe communication deficits. This was surprising, given the large number of individuals who were identified also as Priority 1 and 2 (nonverbal with or without behavioral concerns). Collaboration between psychology and SLPs appeared to be improved, though only for a limited number of individuals. The SLPs inconsistently attended BSC meetings. Continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP. There were pockets of excellence, however. For example, Kristi Hodges' work with psychology for one individual (excellent case study presented at QAQI Council), though the same kind of supports were needed for many more individuals with communication needs. The facility is commended for recognizing the need for greater attention to communication issues by extending the time in NEO for staff instruction by therapy clinicians. Annual refreshers are also needed in this area. The SLPs who specialize in communication, must be considered key members of the IDT. They should be notified of all ISPA team meetings and when are in attendance, the have the same responsibility as all team

	members. Communication supports and services must be clearly integrated into the ISP. The following samples were used by the monitoring team: • Sample R.1: 3 individuals included in the sample (one best and most current assessment selected and submitted by the facility for each clinician). • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals receiving direct speech services

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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> The Director of Habilitation Therapies, Danielle Perry, AuD, CCC-A continued in this role as in the previous review. It was reported that there were six other full time SLPs with three of these assigned responsibilities related primarily to communication. They were Chris Pedroni, MS, CCC-SLP, Kristi Hodges, MA, CCC-SLP, and Maegan Melton, MS, CCC-SLP. Ms. Melton was on leave at the time of this. There was one SLPA, Audrey O'Berry. The ratio of SLPs based on the current census (338) was approximately was 1:112. The SLPA ratio was 1:338 for direct and indirect supports other than assessment. These ratios were excessively high and severely limited the availability of speech clinicians to the individuals living at LSSLC. Responsibilities of the therapists (SLPs) included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to both communication and dysphagia. The speech staff were assigned caseloads as follows: • Chris Pedroni: Castle Pines and homes 523 and 520B (approximately 107 individuals). • Kristi Hodges: Woodland Crossing and Home 524 (approximately 119 individuals). • Maegan Melton: Lone Pine and Homes 520A, 529, 539, and 542 (approximately 119 individuals). • Audrey O'Berry: As assigned, currently 44 individuals. She provided assistance and supports to the SLPs in all homes (as required and directed by the SLPs). The Master Plan listed assigned priorities related to the severity of individual communication deficits and dates of completion of the comprehensive communication assessments, updates, and screenings. Based on this plan, only 58 individuals were listed with comprehensive assessments completed since 2010. Completion dates were as	Noncompliance

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		follows: 2010 (3), 2011 (7), 2012 (26), and 2013 (20). Eleven screenings and 21 updates had been completed in 2013, with only two assessments and one screening completed in 2012. Per the process in place, when a Comprehensive Evaluation was completed, an Assessment of Current Status (previously referred to as an update) was subsequently completed on an annual basis for individuals who were provided supports and services. Repeat Comprehensive Evaluations were recommended and completed at a prescribed interval (every three to five years) as designated in the communication assessments. Seventeen individuals were provided an update who had previously received a comprehensive assessment, though in some cases, the assessment had been two or three years earlier, rather than annually as would be expected for individuals who were provided communication supports (Individual #360, Individual #542, Individual #542, Individual #84, Individual #248, Individual #300, and Individual #480, for example). On the other hand, others were provided an update with no evidence of a previous comprehensive assessment (Individual #440, Individual #326, Individual #188, Individual #571, and Individual #592). Still others were not provided either a comprehensive assessment or update, yet were listed with communication supports (Individual #10, Individual #568, Individual #60, Individual #179, Individual #333, Individual #117, Individual #294, Individual #503, Individual #205, Individual #458, and Individual #392). At least nine individuals who were provided communication supports had not received an update or Assessment of Current Status since the comprehensive assessment listed in the plan. No evaluations were provided to individuals newly admitted to the facility, and only 50% of those admitted since 6/1/13 had been screened for communication needs. There were 122 individuals listed in the Master Plan as Priority 1, those who were nonverbal and/or with behavioral concerns. The clinicians reported that they would focus on assessment and supports for this group over the next six months period, before addressing needs for individuals in the other priority groups. During the pre-ISP, if a specific communication issue was identified, the therapist would address that rather than provide a comprehensive assessment for those individuals who were not categorized as Priority 1. Another 111 individuals were designated as Priority 2, those with limited verbal skills. Both of these groups would likely require some level of communication supports. Only 38 individuals who were listed as Priority 1 and only 11 listed as Priority 2 had been provided a comprehensive assessment. Though the plan to focus efforts on those identified as Priority 1 as of 10/1/13 was understandable given the current staffing level, there continued to be a large number of individuals with likely communication needs who would not be sufficiently addressed. The list of individuals with behavioral concerns contained 203 individuals; each	

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		identified with PBSPs and severe language deficits, representing 60% of the current census. Another list identified 135 individuals with PBSPs and replacement behaviors related to communication. At least 58 individuals were listed with AAC systems and 46 individuals were listed with direct speech therapy. Based on the identified needs, per the documentation submitted, the existing staffing was insufficient. It was not clear, however, that the facility had fully established the extent of communication needs for all individuals due to the lack of assessments. This was necessary, in order to establish staffing needs. In a previous review, the monitoring team had encouraged the clinicians to provide necessary supports and AAC, despite the absence of evaluations. It should be noted, however, that they had since been encouraged to proceed with assessments, though their success with this was limited. For example, only 12 evaluations by the three clinicians were completed since the previous review. One clinician had completed only one assessment during that period. Further, two of these had not been submitted on/prior to the due date. Four others were submitted via an ISPA for team review rather than at the ISP, which had previously been conducted and, as such, were also considered to be delinquent. The tracking log inaccurately identified their due dates as "N/A." In each of these cases, a subsequent update would be required at the time of their upcoming ISPs. The lack of assessments continued to be unacceptable, though the supports being provided otherwise continued to be strong. While the monitoring team acknowledged that the staffing levels were low, it appeared that there had been a lack of focus on the completion of assessments. <u>Qualifications:</u> • The facility documented appropriate qualifications for licensed SLPs. • 4 of 4 speech staff (100%) were currently licensed to practice in Texas as verified online. This was consistent with the previous review. • 3 of 3 SLPs (100%) were listed with current ASHA certification as of 12/31/13, per the self-assessment (12/30/13). It was not known to the monitoring team, however, if these were then renewed. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 4 of 4 current speech staff (100%) had completed continuing education related to communication since the previous review, though this was extremely limited. Each clinician attended the state-provided Habilitation Therapy Conference, which offered 23 contact hours, though only three of the nine topics listed related to communication. One of these was a presentation by one of the four LSSLC clinicians, Kristi Hodges, related to her work with one of the individuals	

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		living at LSSLC. An abbreviated version of this was presented to QAQI Council and the monitoring team during the onsite review. It was an excellent presentation and highlighted some of the outstanding services provided. The actual contact hours for the communication-related topics during the conference could not be determined. Only two clinicians appeared to have attended any other communication-related continuing education (Chris Pedroni and Maegan Melton). All other education was state-provided and/or required. Continuing education attended by the clinicians for which contact hours or CEUs were provided that appeared to be potentially relevant to communication included: • Motivating Children with Autism to Speak: Incorporating ABA Principles to Build Functional Communication, 5 contact hours (Pedroni) • Measurable Goals and Skill Acquisition Programs, hours not documented (Pedroni, Hodges, and O'Berry) • Cognitive Rehabilitation and Memory Enhancement, 6 contact hours (Melton) The intent of ongoing continuing education is to ensure that the clinicians attain and/or expand their knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. The clinicians are encouraged to continue to seek continuing education courses beyond in-house training to continue to enhance their talents relative to the provision of communication supports and services. Inservices conducted by co-workers following attendance at formal continuing education courses is an excellent method to conserve resources, yet permit all staff to benefit from the information acquired. A system to track participation in continuing education was in place at LSSLC. <u>Facility Policy:</u> Per the self-assessment, the speech policy had been reviewed and revised on 11/26/13. A policy dated 1/15/14 was submitted as requested. The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services: • Roles and responsibilities of the SLPs. • Outlined assessment/update schedule including frequency and timelines for completion of new admission assessments, timelines for completion of Comprehensive Assessments, and timelines for completion of Comprehensive Assessment/Assessment of Current Status and assessments for individuals with a change in health status potentially affecting communication. • Criteria for providing an Assessment of Current Status versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP.	

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		• 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. Each of these was generally addressed in the policy, though it was recommended that more specific procedures be documented for consistency of implementation. A system of compliance monitoring continued to be in the process of review and development. The monitoring team concurred with the self-assessment of noncompliance. 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 local policy that outlined the elements listed above. 2. Clearly establish the level of communication supports and services needs for the individuals living at LSSLC. 3. Establish a process for determining staffing to meet those identified needs. 4. Ensure that all speech therapists participate in communication-related (particularly AAC) continuing education applicable to individuals with developmental disabilities to promote an understanding of their role in the provision of supports and services to the individuals living at LSSLC.	
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.	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion during the onsite review week with the habilitation therapies director, Danielle Perry, AuD, CCC-A, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample) because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Assessment Plan:</u> As described above, only 17% of individuals listed in the Master Plan had been provided a comprehensive assessment. Eleven others had been screened for communication needs, though this had been provided to only 50% of the individuals newly admitted to LSSLC since 6/1/13. It was expected in the case that the screening identified communication needs, a comprehensive assessment would be completed at that time. In no case was there evidence that a comprehensive assessment had been completed for those screened, though two individuals had been provided AAC (Individual #588 and Individual #59).	Noncompliance

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		Completion of assessments was generally based on the ISP schedule and re-evaluation was conducted on an interval to be designated in the evaluations. Assessments of Current Status were to be completed for individuals who received supports and services in years that a Comprehensive Evaluation was not required. Assessment due dates and timeliness of completion were tracked in the tracking log for individuals from 7/23/13 through 11/18/13. There were only 12 individuals listed as provided an annual communication assessment since 7/23/13. Of those listed, however, only six had been completed on time, or within 10 days prior to the ISP. Four others were submitted via ISPAs rather than at the time of the ISP. Each of these was also considered by the monitoring team to be delinquent because each individual had an ISP for which no communication assessment had been submitted. The tracking log inaccurately identified their due dates as "N/A." In each of these cases, a subsequent update would be required at the time of their upcoming ISPs. The lack of assessments continued to be unacceptable, though the supports being provided otherwise continued to be strong. While the monitoring team acknowledged that the staffing levels were low, it appeared that there had been a lack of focus on the completion of assessments. <u>Assessments Provided</u> One of the best and the most current assessments selected by each speech clinician were requested for review based on proposed reduced monitoring for this element. Communication assessments were submitted as follows: • Speech Language Evaluation 2. Individual #308 (10/18/13) 3. Individual #20 (10/22/13) • Speech–Language/Communication Skills Comprehensive Evaluation 1. Individual #410 (12/13/13) • 3 of 3 individuals (100%) in Sample R.1 were provided an assessment or update current within the last 12 months. • 4 of 8 individuals (50%) listed as admitted between 6/1/13 and 11/18/13 received a screening. Each was listed as completed within 30 days of admission in the tracking log though none were submitted for review. None had been provided an assessment. Per the self-assessment, 100% of the new admission screenings had been completed in a timely manner from December 2012 through November 2013. It was noted, however, that there had been eight admissions since 6/1/13 through 11/18/13, yet only six were included in the data presented for this element in the self-assessment. • 3 of 3 individuals (100%) for whom assessments/assessments of current status	

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		(current within the last 12 months) were dated as having been completed at least 10 working days prior to the annual ISP. Though screenings were reported to be completed for individuals newly admitted, none were submitted and none were included in the assessment tracking log. Based on the data included in the Master Plan, 12 screenings were completed, and at least two had identified needs (AAC provided to Individual #588 and Individual #59). • If screenings were completed, 0 of 2 individual identified with therapy needs through a screening (0%) received a comprehensive communication assessment within 30 days of identification. <u>Communication Assessment:</u> Based on review of the sample of assessments submitted and included in Sample R.1, there were three individuals with current comprehensive assessments (Individual #308, Individual #410, and Individual #20) completed by each of the three speech clinicians. These were included in the analysis below. None of the assessments reviewed had all of the essential elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. The current state and local LSSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the communication assessments were as follows: • 3 of 3 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was consistent with the previous review. • 3 of 3 assessments (100%) included diagnoses and relevance of impact on communication. This was consistent with the previous review. • 3 of 3 assessments (100%) included individual preferences and strengths. This was consistent with the previous review. Though these were listed in some assessments, they were not used to guide the development of communication strategies or AAC systems. • 3 of 3 assessments (100%) included medical history and relevance to communication. This was an improvement from 75% in the previous review. The clinicians should consider including pertinent past medical history and current health status over the last year, with better analysis of whether the individual's function was impacted as a result. • 2 of 3 assessments (67%) listed medications and discussed side effects relevant to communication. This was a decrease from the previous review (88%). The evaluation for Individual #410 identified that he was on medication for specific health concerns and identified side effects and the potential impact of these on his communication, but did not list the actual medications.	

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		• 1 of 3 assessments (33%) provided documentation of the relationship between the individual's communication abilities and his/her risk levels. This was a decrease from the previous review (63%). o The assessment for Individual #410 did not indicate if his communication skills impacted risk levels other than behavioral health. It may be assumed by the reader that there was no relationship between communication and the other risk areas, but this should be clearly stated. The clinician addressed only that behavioral health required communication-related supports and services. o The assessment for Individual #20 addressed only that behavioral health was pertinent to the communication evaluation. This element required the clinicians to determine whether any areas of risk would be impacted by the individual's communication skills or whether there was any other relationship between communication and areas of risk, such as challenging behaviors. Further, the inability to express the specific source of pain or discomfort, for example, would require special supports to ensure that staff could interpret other behaviors that might provide clues for intervention. • 3 of 3 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. • 2 of 3 assessments (67%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was a similar to the 63% in the previous review. • 3 of 3 individuals' communication assessments (100%) 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. This was an improvement from 38% in the previous review. • 3 of 3 individuals' communication assessments (100%) included discussion of the expansion of the individuals' current abilities. This was an improvement from 88% in the previous review. • 2 of 3 individuals' communication assessments (67%) provided a discussion of the individual's potential to develop new communication skills. This was a decrease from 100% in the previous review. • 0 of 3 assessments (0%) included the effectiveness of current supports, including monitoring findings. This was a decrease from 25% in the previous review. While the effectiveness of current supports was addressed, monitoring results were not reported in these assessments. • 2 of the 3 assessments (67%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the	

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		individual would benefit from AAC or EC. This was a decrease from 88% in the previous review. One assessment reported AAC assessment from previous evaluations rather than findings from current assessment by the clinician. • 3 of 3 assessments (100%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 25%. • 3 of 3 assessments (100%) gave a comparative analysis of current communication function with previous assessments. This was an improvement from 75% in the previous review. • 3 of 3 assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was an improvement from 75% in the previous review. • 3 of 3 assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was an improvement from 63% in the previous review. The content varied across the three assessments from very thorough to limited. • 3 of 3 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 3 of the 3 assessments (100%) supplied a monitoring schedule. This was an improvement from 25% in the previous review. • 3 of 3 assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was consistent with the previous review. • 3 of 3 assessments (100%) made a recommendation about community referral and transition. This was consistent with the previous review. • 1 of 3 assessments (33%) included specific recommendations for services and supports in the community. This was a decrease from 50% in the previous review. • 3 of 3 assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was an improvement from 63% in the previous review. Additional findings related to the communication assessments were as follows: • 1 of 3 assessments (33%) contained 90% or more of the 23 elements listed above. • One contained 87% compliance. • One contained only 70% of the required elements. • The average was 84% for all assessments. • Sixteen elements were noted to be present in 100% of the assessments reviewed. Four elements were present in 67% of assessments. Two were present in only 33% of the assessments reviewed.	

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		o The element related to monitoring findings was not present in any of the assessments reviewed • Improvements from the previous review were noted for 48% of the 23 elements. • Seven elements (30%) remained consistent with the previous review, at 100%. • Decreases were noted for five elements (22%). A system of assessment audits implemented by the department for the establishment of competency of the speech clinicians was established, including self-assessment, audit by the director, and by an external consultant. Per the self-assessment, there were 72 assessments due for ISPs scheduled from December 2012 through December 2013. There were only 18 assessments completed during that time (25%) and only eight of those (44%) were completed within the designated time frame. The Master Plan was analyzed in the self-assessment and it was reported that there were 322 ISPs scheduled from December 2012 through December 2013. Only 69 individuals were identified as requiring a comprehensive assessment during that year, though only 18 were completed. The method used to determine whether a comprehensive assessment was required was not identified. • --% of updates submitted in Sample R.1 were completed consistent with the established schedule, or the individual's need. This metric was not reviewed at this time. • Based on the data contained in the Master Plan submitted, 18 of 23 updates (78%) had an associated comprehensive assessment, but because these were not reviewed, it could not be determined that these were consistent with the established format and content guidelines. <u>SLP and Psychology Collaboration:</u> There were 203 individuals identified with behavioral issues and co-existing severe language deficits (nonverbal or limited verbal skills). There were 135 individuals listed with PBSPs who also had replacement behaviors related to communication. There were approximately 25 meetings held to review PBSPs from 6/4/13 through 11/29/13 and a speech representative attended only two of the meetings held, per the meeting minutes. Alternatively, a database maintained by speech therapy documented attendance at these meetings and the individuals reviewed at each. Based on these data, there were 24 meetings held from 7/9/13 through12/31/13 and a SLP attended 14 (58%) of these meetings. The database documented if the individual had communication issues, behavior issues, required changes to the PNMP, and date that the change had been made. Participation in the review of PBSPs during these meetings was an important opportunity to promote collaboration between psychology and the SLPs. It is	

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		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 also document those efforts. Further it is encouraged that the facility ensured that there was adequate integration between the PBSP, the communication assessment, PNMP and recommended strategies. Progress was made in this provision. The facility had requested reduced monitoring for this provision and had self-rated noncompliance. The monitoring team concurred based on the findings reported 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. Develop a plan, to include benchmarks to address the completion of communication assessments for individuals in a timely manner, while not reducing the current supports and services provided. 2. Initiate continued collaboration with psychology to identify strategies to ensure integration of communication strategies in the PBSPs, including regular participation in the Behavior Support Committee. 3. Clarify the function of the Comprehensive Evaluations versus the Assessments of Current Status based on the forthcoming changes as to formats as required by the State. 4. Ensure that the essential elements for assessments identified above are addressed in all assessments by all speech 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.	Though the parties previously agreed that the monitoring team would conduct full monitoring for this subsection, based on discussion during the onsite review week with the habilitation therapies director, Danielle Perry, AuD, CCC-A, the monitoring team agreed to conduct reduced monitoring (i.e., updates and smaller sample) because the facility had made limited progress. The noncompliance finding from the last review stands. <u>Integration of Communication in the ISP:</u> The following metrics were not addressed because only one of the three assessments had an associated ISP submitted (Individual #308). The ISPs for Individual #410 and Individual #20 had not yet occurred. • For --% of individuals in Samples R.1, a SLP was in attendance at the ISP. • For --% of individuals, communication strategies identified in the assessment were included in the ISP. • In --% of ISPs for individuals with communication supports (--%), the type of AAC and/or other communication supports (e.g., Communication Dictionary)	Noncompliance

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		were identified. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for --%, as evidenced in the ISP. Some only mentioned the dictionary as a support, but did not reflect IDT review. • --% of ISPs included a description of how the individual communicated and how staff should communicate with them. The ISP consistently described how the individual communicated, but did not consistently include how staff should communicate with them. • --% of ISPs contained skill acquisition programs to promote communication, though most presented with significant language deficits. • --% of ISPs included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP. The system of pre-ISPs continued to be relatively new and the IDTs did not appear to fully understand the process required to determine who was required to attend the ISP meeting. Based on the self-assessment, very few ISPs identified the need for the communication specialist to attend the annual meetings despite the high number of individuals with severe communication deficits. There is a need to ensure that required attendance is accurately determined and that the appropriate clinician be in attendance for those meetings. <u>Individual-Specific AAC Systems:</u> Approximately 47 individuals were listed with one or more types of communication systems. These systems were generally portable, functional, and individualized. There were 27 individuals who had been provided only a comprehensive assessment, or a comprehensive assessment and subsequent update. There were four who had been provided an update only and two who had been provided a screen only. There were 46 individuals listed as participating in direct communication therapy intervention at the time of this review. Most were related to the provision of AAC. Communication dictionaries were also provided to individuals at LSSLC, though the number of these could not be determined based on the documents submitted. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This enhanced staff understanding of the individual and promotes consistent responses, but did not specifically enhance or improve the individual's expressive or receptive skills. These were identified in the three assessments though it could not be determined if these were reviewed annually by the IDT for effectiveness as current ISPs were not submitted for each of the individuals included in the sample.	

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		One of the assessments provided an excellent assessment of the individual's potential for AAC use (Individual #308). The assessment for Individual #20 was brief and presented information related to the existing AAC supports provided, but did not address if these were the most appropriate for her based on that current assessment. The assessment for Individual #410 did not reflect any current assessment of his need for AAC, but rather reported information from previous assessments and, thus, determining only that he did not want to use the devices previously provided. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized during the assessment process to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings with attempts made for use in settings over time in order to spark interest, such as to request a favorite item, food, beverage, music, vibration, or massage, for example. <u>General Use AAC Devices:</u> There were a limited number of general use communication devices. None were seen in use during this review. <u>Direct Communication Interventions:</u> There were 46 individuals listed as participating in direct communication-related interventions. 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 were included in the documents submitted for review (Sample R.3). This included assessments, ISPs, ISPAs, SAPs, and progress notes. In two cases (Individual #294 and Individual #333), there were no assessments for the individuals to establish the rationale for direct communication interventions as documented in a comprehensive assessment, update, or progress note. There was no evidence that the need for direct therapy had been reviewed by the IDT in the ISP or an ISPA. While therapy was referenced in their most current ISPs, there was	

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		no evidence of assessment findings or measurable objectives. In the case of Individual #535, a recent communication assessment had been completed on 9/17/13, yet this update (the previous comprehensive assessment, dated 10/2/12, was not contained in the individual record) referred to therapeutic intervention in progress at that time. The initial comprehensive assessment had been completed in September 2012, yet a diagnostic trial for AAC training had not been initiated until December 2012. Measurable objectives were clearly established. Individual #535 demonstrated progress with these goals and the update recommended that he continue direct intervention with revised measurable goals. As documentation of direct therapy for the individuals in this sample was limited only the following metrics were not addressed by the monitoring team: • For --% of individuals, a direct intervention plan was implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. • For --% of individuals, the current SLP assessment identified the need for direct intervention with rationale. • For --% of individuals, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For --% of individuals, the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). • For --% of individuals, there was a description of the benefit of the device and/or goal to the individual. • For --% of individuals, consistency of implementation was documented. • For --% of individuals, recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • --% of individuals for whom direct intervention had been discontinued, termination of the intervention was well justified and clearly documented in a timely manner. • --% of individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the indicators listed below: o Contained information regarding whether the individual showed progress with the stated goal. o Described the benefit of device and/or goal to the individual. o Reported the consistency of implementation. o Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress.	

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		o Completed at least monthly. While session notes appeared to be completed routinely, monthly summaries were not consistently completed, readily permitting an analysis of progress related to the measurable goals and objectives. This is critical, particularly when the SLPA was providing the service. The progress notes were not included in the IPNs, but rather on a special speech progress note form and filed in the Habilitation Therapy tab. While this was acceptable for daily or session notes, a monthly summary should be completed in the IPNs, so progress may be effectively referenced by other IDT members. Additional initiatives implemented since the last review were summarized in the Presentation Book for this section. Communication Training Centers were established with a focus on AAC to provide a hands-on opportunity for individuals to participate in life-skills activities on a trial basis. A screening process was to determine the need for referral for evaluation or the development of a SAP for home-based implementation. The proposal for this project was scheduled to begin on 10/22/13 in home 510 and on 11/13/13 in home 560, one day a week. It appeared that this was initiated as a communication class scheduled two times a week in home 510 as of 12/30/12. There were eight individuals listed as enrolled in this class. The communication clinic in the wheelchair shop continued for Woodland Crossing and Lone Pine. Communication devices are reviewed to ensure they were in good working condition. One time monthly the SLP attended in order to try out new devices and participated in problem-solving related to AAC, mounting and positioning related to these devices. Each of these were excellent methods to achieve the provision of appropriate communication systems for individuals. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication dictionaries, and general use AAC. These supports were identified in the annual assessment and described in the PNMP, which provided clearly stated instructions for staff. Other indirect supports were developed in the form of SAPs implemented by DSPs in the day program or work areas, though these were very limited. Frequency and consistency of review of these was not reviewed at this time. <u>Effectiveness Monitoring</u> This type of monitoring should address communication plans and AAC, dictionaries, and SAPS related to other indirect communication supports. The frequency of effectiveness monitoring may be based on individual risk or the intensity of supports provided, but should be conducted no less than quarterly (the annual assessment may serve as the fourth quarter review), and clearly stated in the communication assessment or be an aspect of the departmental policy and procedures. This monitoring should address any	

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		changes in risk or status of the individual since the previous review and staff compliance, as well as whether the supports and/or strategies effectively met the intended need. Frequency should be included in the ISP with documentation in the IPNs. These notes should include the following: • Previously unresolved issues • PNM Risk occurrences since the previous effectiveness monitoring that impact communication • Purpose and function of the device or support • Presence and condition of equipment • Staff knowledge and compliance • Analysis of program effectiveness including progress, regression and maintenance as well as if the plan remained current and appropriate • Identification of issues with recommendations for changes as indicated including the person responsible and timelines for completion At the time of this review, effectiveness monitoring was reported to be completed at least quarterly, though this was not consistent. <u>Competency-Based Training and Performance Check-offs:</u> LSSLC had a system of comprehensive competency-based training regarding communication services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Class time included four hours (an increase from two hours since the previous review) to communication and AAC. The new content was implemented as of December 2013, though the curriculum materials were not submitted for review. This included instructional content and foundational skills, with modeling by the trainers, to new employees. New employees were required to take a combination of written tests and were checked off on specific skills, using the checklists. Employees were expected to pass all essential elements of the core competencies and written examinations. Check-offs were repeated up to three times. If staff did not pass the check off with the instructor, they were re-tested with an alternate instructor. If the staff again failed to pass, they were checked off a third time by a SLP and the home manager was present. If they again failed to pass, the employee was terminated at that time. At any time the employee could be required to repeat the class.	

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		The training materials though not reviewed should address the minimum foundational content areas listed below: • Identification of nonverbal means of communication. • Strategies to enhance individual participation in routines throughout the day • How to be an effective communication partner • Methods to enhance communication • Implementation of communication plans and programs • Benefits and use of AAC The following metrics were intended to address the compliance with training as intended via the Settlement Agreement. • --% of new employees had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. • --% of staff required to take the Annual Refresher class. There was no refresher in the area of AAC/communication implemented at LSSLC at the time of this review. • There was/was not a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. <u>Individual-Specific Competency-Based Training</u> The facility was in the process of implementing a system (red dot) to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. This was being initiated, at first, only for dining plans and PNMPs. The red dot was intended to alert staff that specialized training was required to implement that aspect of a plan. Only staff who had completed competency-based training were permitted to implement those techniques. This was in the early stages of implementation at this time. The following metrics were intended to address the compliance with training as intended via the Settlement Agreement, though not reviewed at this time. • Per the system in place, --% of the staff assigned to individuals in the samples selected by the monitoring team were trained related to the PNMP prior to the provision of services. • Per the system described, --% of the staff assigned to individuals in the samples selected by the monitoring team had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. • --% of staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the	

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		PNMP/Dining Plan. • The facility did or did not have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though somewhat improved, there was insufficient assessment of the AAC needs, though provision of these supports continued to be expanded for individuals with identified with needs means other than formal assessment at this time. The process of effectiveness monitoring was not conducted consistently. 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. 2. Address quality of implementation and documentation of direct and indirect supports as recommended. Ensure that individuals who participated in direct and/or indirect communication supports were provided a comprehensive evaluation and interim annual updates to establish the rationale for intervention. This should include routine effectiveness of all communication supports provided.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plans (ISPs) for: • Individual #357, Individual #344, Individual #466, Individual #93, Individual #112, Individual #383, Individual #387, Individual #492, Individual #245, Individual #337, Individual #43, Individual #117, Individual #74, Individual #458, Individual #143, Individual #116, Individual #410 o Skill Acquisition Plans (SAPs) for: • Individual #337, Individual #43, Individual #117, Individual #74, Individual #458, Individual #27, Individual #480, Individual #20, Individual #62, Individual #51, Individual #139, Individual #144, Individual #124, Individual #213, Individual #128, Individual #515 o Monthly review of SAP progress for: • Individual #337, Individual #43, Individual #117, Individual #74, Individual #458 o Functional Skills Assessment (FSA) for: • Individual #337, Individual #43, Individual #117, Individual #74, Individual #458 o Personal Focus Assessment (PFA) for: • Individual #337, Individual #43, Individual #117, Individual #74, Individual #458 o Vocational assessments for: • Individual #337, Individual #43, Individual #117, Individual #74, Individual #458 o Integrity check for skill acquisition programs, 10/7/13 o Section S Presentation, undated o Section S self-assessment, 12/30/13 o Section F and S Presentation Book, undated o Section S Action Plan 12/28/13 o A list of individuals who are employed on and off campus, undated o Description of on and off campus day and work program sites, undated o A list of all instances of skill training provided in the community, July 2013-November 2013 o A list of community outings per home, July 2013-Novemeber 2013 o List of individuals with dental desensitization plans, undated o List of individuals who were eligible for educational services, including their assigned school and hours of attendance, School year 2013-2014 o IEPs, ISD progress notes/report cards, ISPs, and relevant ISPAs for • Individual #344, Individual #143, Individual #116 o Data and graphs showing number of returns to LSSLC from public school mid-day o Daily student LSSLC-campus classroom schedule

	o Table of data showing each student's attendance in class at the LSSLC on-campus classroom, August 2013-December 2013 o Data on mid-school-day returns to LSSLC, table and graphs, September 2013-December 2013 <u>Interviews and Meetings Held</u>: o Luz Carver, QIDP Coordinator o Luz Carver, QIDP Coordinator and LSSLC Liaison to LISD; Mary Gill, Assistant to Ms. Carver; and Jay Bamburg, Ph.D., consultant to LSSLC o Suzanne McWhorter, QIDP Coordinator Assistant o Cindy Jones, Active Treatment Coordinator o Jay Bamburg, Ph.D., consultant to LSSLC o Keith Baily, Residential Services Manager; Mary Stovall, Oak Hill Unit Director; Kenneth Self, Woodland Crossing Unit Director; Rotley Tankersley, Castle Pines Unit Director; Todd Miller, Lone Pines Unit Director <u>Observations Conducted</u>: o ISP meeting for: • Individual #410 o Pre-ISP meeting for: • Individual #326 o SAP peer review meeting o Pretreatment Sedation Committee meeting o SAP implementation for: • Individual #515 o SAP integrity session for: • Individual #515 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. The monitoring team believes, however, that some items in the self-assessment could better reflect the activities that the monitoring team assesses. For example, S2 of the self-assessment appeared to focus on ensuring that functional skills assessments, vocational assessments, and preference and strengths Inventories were completed. This is important, however, the focus of S2 in the monitor's report is on determining if assessments were clearly used to select individual skill acquisition plans. Additionally, in S3a the monitoring team's report assesses if decisions concerning the continuation, discontinuation, or modification of SAPs are databased. That topic is not included in the self-assessment.

	The monitoring team suggests that the facility review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made in 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 all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facility's findings of noncompliance in all areas. The self-assessment established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur throughout the facility, and because it will likely take some time for LSSLC to make these changes, the monitoring team suggests that the facility establish, and focus its activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, the monitoring team noted several improvements since the last review. These included: • A re-organization of staff responsible for writing skill acquisition plans (SAPs) (S1) • Modification of the SAP format (S1) • Improvement in the percentage of SAPs that contain a rationale for its selection that is specific enough for the reader to determine that it was practical and functional for that individual (S1) • Improvement in the percentage of SAPs that contain a maintenance plan that is consistent with the definition below (S1) • Improvements in individual engagement (S1) • Continuous progress in pretreatment sedation reduction (S1) • Initiation of SAP integrity (S3) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that all SAPs are in the new format (S1) • Ensure that each SAP has a plan for generalization that is consistent with the definitions below (S1) • Expand the number of communication SAPs for individuals with communication needs (S1) • Establish engagement targets for each home and day program site, and ensure that those levels of individual engagement are achieved (S1) • Document that functional skills assessments, preference and strengths inventories, and vocational

	assessments are completed and available to team members at least 10 days prior to each individual's ISP (S2) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of all skill acquisition plans (S2) • Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are data based (S3) • Ensure that SAP integrity is assessed in all treatment sites, establish acceptable levels of SAP integrity, and provide performance feedback to staff to ensure that goal levels of SAP integrity are achieved (S3) • Ensure that measures of skill training in the community are accurate (S3) • Establish goal 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 was progress since the last review, more work (discussed in detail below) is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at LSSLC had multiple skill acquisition plans (SAPs). The facility recently reorganized the department and, at the time of the onsite review, four program developers wrote SAPs. SAPs continued to be implemented by direct support professionals (DSPs). The DSPs were trained in SAP implementation and monitored by active treatment coordinators. Vocational SAPs were written and monitored by employment services personnel. An important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Individual Support Plan (ISP), adaptive skill or habilitative assessments, psychological assessment, and individual preferences. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. As discussed in the last report, the facility recently established 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. The monitoring team observed a SAP review meeting and continued to be impressed with the quality of the reviews, and encourages the facility to continue to conduct these meetings.	Noncompliance

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		In addition to the introduction of program developers to write SAPs, LSSLC recently developed a new SAP format to ensure it was consistent with the new DADS policy. The monitoring team reviewed a total of 38 SAPs across 16 individuals. Only 14 of those SAPs, however, were written by program developers and were in the new format. Therefore, only those 14 SAPs will be reviewed to assess compliance with this provision item. Moving forward, it is recommended that all SAPs be written in the new format. In 12 of the 14 new format SAPs reviewed (86%), the rationale appeared to be based on a clear need and/or preference. This represented a dramatic improvement from the last review when only 68% of the SAPs appeared practical and functional. An example of a rationale that appeared to be based on a clear need and/or preference was: • The rationale for Individual #213's SAP of applying lotion to moisturize her skin included that she had dry skin that cracks and leads to infections 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 #27's SAP of washing himself stated that he required assistance to wash his arms and chest. 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 a rationale that is specific enough for the reader to understand that the SAP was practical and functional for that individual. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response	

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		• Plan for maintenance and generalization, and • Documentation methodology The new SAP format contained all of the above components. Additionally, the quality of some of these components was improved. For example, all 14 of the SAPs in the new format reviewed (100%) included a complete plan for maintenance. This represented another significant improvement over the last report when 72% of maintenance plans were judged to be complete. 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. Eleven of the 14 new format SAPs reviewed (79%) included a plan for generalization that was consistent with the definition below. This was consistent with the last report when 80% of the generalization plans were judged to be consistent with the definition below. An example of a complete generalization plan was: • The plan for generalization in Individual #51's SAP of safely crossing the street indicated that once he mastered this SAP he would be encouraged to safely cross the street at LSSLC and during community excursions. Examples of unacceptable plans for generalization included: • The plan for generalization for Individual #128's SAP of inserting earplugs stated she should insert the earplugs whenever she took a bath. The purpose of teaching Individual #128 to use the earplugs was to keep water out of her ears. Therefore, a generalization plan consistent with the above definition might include encouraging her to use the earplugs before bathing, washing her face, swimming, etc. • The plan for generalization for Individual #20's SAP of exercising said she would exercise for 60 minutes without prompting. A more complete generalization plan could include encouraging her to engage in different types of exercise, or generalize the times or duration of exercise, and/or generalize the location of her exercise It is recommended that LSSLC ensure that all SAPs contain a generalization plan that is consistent with the definition above. The facility continued to use several training methodologies to train SAPs. Additionally, all of the new format SAPs contained clear behavioral objectives, and training instructions that represented another improvement from the last review.	

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		The monitoring team was encouraged by the reorganization of SAP writing at LSSLC and the subsequent improvements in the quality of SAPs reviewed. Over the next six months, it is recommended that facility ensure that all SAPs are in the new format, and that generalization plans are consistent with the above definition. <u>Dental compliance and desensitization plans</u> The facility continued to make progress in this area. As discussed in previous reports, the behavioral health services department had 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. A pretreatment sedation meeting that reviewed these plans and other interventions to decrease the use sedating medication for routine dental/medical procedures continued to meet. The majority of plans to address refusal to allow routine dental exams appeared to be addressed with informal strategies designed to increase compliance. All plans/strategies to increase compliance with routine oral hygiene and dental exams are documented in individual integrated health care plans (IHCPs). The overall use of sedating medications continues to be reviewed (see Q2) and will be used as measure of the success of these plans/strategies. At this point, LSSLC appears to be continuing to make 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 skill should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. <u>Communication and language skill acquisition</u> Only one (i.e., Individual #117) of the 16 individuals reviewed (6%) had a skill acquisition program targeting the enhancement or establishment of communication and language skills. This was a slight improvement over 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).	

#	Provision	Assessment of Status	Compliance
		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 observed staff consistently attempting to engage individuals in active treatment at LSSLC. Additionally, there appeared to be improvements in engagement in the day programs. For example the average percentage of individuals engaged in the 560 building was 49%, which was a notable improvement from the last review when engagement in the 560 building averaged 38%. The table below lists the monitoring team's measures of individual engagement across various day and residential settings at LSSLC. The average engagement level across the facility was 66%, an improvement from the last two reviews when engagement was 53% and 47%. The facility continued to collect individual engagement data. The self-assessment indicated that from July 2013 to November 2013 the average percentage of individuals engaged across the four residential units was 76%, about the same as they reported in the last review. As discussed in the last report, the absolute differences between the facility's engagement scores and the monitoring teams scores are likely due to the different methods used. The monitoring team was encouraged by the steady improvements in individual engagement at LSSLC. It is now recommended that engagement targets for each home and day program site be established, and that the facility ensure that those levels of individual engagement are achieved.	

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Engagement Observations:

Location	Engaged	Staff-to-individual ratio
520-B	2/2	2:2
523	1/4	2:4
523	2/2	1:2
523	1/4	2:4
563-A	5/5	2:5
563-A	3/3	1:3
561-B	0/4	1:4
561-B	6/6	2:6
561-B	1/1	1:1
561-B	1/3	0:3
561-A	2/2	2:2
561-A	2/3	1:3
520-A	4/4	4:4
524	1/4	1:4
524	3/7	3:7
524	4/8	3:8
529	4/4	1:4
Transition home	3/3	1:3
559-A	3/4	1:4
559-A	2/4	1:4
559-A	2/4	1:4
559-A	3/4	1:4
559-B	5/5	1:5
559-B	4/4	1:4
557-B	5/8	1:8
557-A	6/8	1:8
510 Building	4/9	3:9
510 Building	1/4	1:4
510 Building	2/4	1:4
510 Building	5/9	2:9
Small Workshop	8/12	4:12
560 Building	4/10	3:10
560 Building	3/4	1:4
560 Building	1/3	1:3
Large Workshop	5/7	2:7

#	Provision	Assessment of Status	Compliance
		Educational Services Eighteen individuals at LSSLC qualified for educational services from the local ISD since the last review. As described in the previous report, LSSLC students now attended Central ISD (a few miles away) rather than Lufkin ISD (about 20 miles away). This was reported by the LSSLC ISD liaison as a good change for the facility, students, and those supporting the students. Of the 18 students, 9 attended school at Central ISD schools (5 at the high school, 4 at the junior high school) and 5 attended the CISD classroom at the LSSLC campus. During an ISP meeting during the week of the onsite review for one of the LSSLC-campus students (Individual #410), the school district proposed a plan to have him begin to attend school at the Central ISD high school building. This was one example of the positive working relationship between LSSLC and CISD to support students to receive a full educational program. The other 4 students remained at Lufkin High School where they were going to finish out their educational program (a decision made with their IDTs). At CISD, the students attended full day, with few returns; an improvement from previous years. This was also reflected in the data that the facility was keeping and had been keeping for a number of reviews. Attendance at the LSSLC-campus school, however, remained low for some students. Overall, this set of students only attended class an hour or so each day. The facility was now collecting data on attendance, as recommended in previous reports. There were also problems in the quality of the educational program students were receiving in this classroom. Both CISD and LSSLC were aware of this and were working on improvements. LSSLC-CISD collaborative work also included lots of email contact between the ISD and facility, involvement of the LSSLC psychologist with ISD staff, visits by LSSLC staff to the schools, visits by school staff to LSSLC, and an individualized transition plan for each of the nine students when the school year began last fall. The monitoring team also looked to see if educational programming was appropriately incorporated into the ISP. Although the school placement was described in the ISP, there was little incorporation of educational activities into action plans and SAPs. During discussion with the monitoring team, the facility staff came up with a number of ways that this could be improved, such as utilizing the already-existing "community trip" sheet to include relevant IEP objectives. The facility should address this. Progress reports and report cards were reviewed regularly by the IDT. In fact, the facility created a specialized ISPA document to document (and prompt) the IDT's review of pertinent aspects of the progress report or report card. This was good to see.	

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		Extended school year/summer programming for 2014 was not yet determined. The monitoring team will review this during the next onsite review.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	LSSLC conducted annual assessments of preference, strengths, skills, and needs. This item was rated as noncompliance, however, because only 42% of SAPs reviewed were clearly based on assessments, and there was no documentation that these assessments were available to team members at least 10 days prior to each individual's team meeting. To assess compliance with this item, the monitoring team reviewed Individual Support Plans (ISPs), Functional Skill Assessments (FSAs), Preference and Strengths Inventories (PSIs), and Vocational Assessments for five individuals. In order to be most useful for the selection and development of SAPs, assessments should be completed and available to team members prior to the ISP. There were no data demonstrating that FSAs, PSIs, and vocational assessments were completed at least 10 days prior to the ISP. As discussed in the last review, the FSA appeared to be an adequate tool for assessing 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 worn, 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. Overall, these five individuals had a total of 24 SAPs, and 10 of those (42%) had documentation that assessments were used to develop them. This represented a decrease from the last review when 61% of the SAPs reviewed included documentation that assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #43's SAP to make purchases was based on her preference (documented in her PSI and ISP) to shop and buy items, and the results of her	Noncompliance

#	Provision	Assessment of Status	Compliance
		FSA that indicated she could not independently make purchases. • Individual #117's ISP documented that he was at risk for falls, and they were most likely to occur during transfers. Therefore, a SAP to teach him to apply his break to his walker before transfers was developed to decrease his risk of falls. • Individual #458's PSI documented that she enjoyed spending her money, and her ISP documented that she had difficulty finding her money when she wanted it. Therefore, a SAP was developed to teach her to place her money in a consistent and secure place (i.e., zipped coin purse). Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #337 had a showering SAP, however, there was nothing in his ISP, FSA, or PSI that suggested that this was a practical SAP for him, or that it was based on any assessment data. • Individual #458 had a SAP to learn to fish. Her SAP indicated that this SAP was based on her preference, however, nothing in her ISP, or PSI indicated that fishing was a preference for Individual #458 • Individual #74's ISP documented that he had a history of poor oral hygiene, so a SAP to brush his teeth independently was developed. His FSA, however, indicated that he was independent in toothbrushing. If it is the case that Individual #74 can brush his teeth independently, but not thoroughly, then, as discussed above, the FSA needs to indicate this so that it is clear that this SAP is based on his assessment results. The monitoring team observed a pre-ISP meeting for Individual #326. The team consistently developed Individual #326's SAPs based on assessments of preference, strengths, skills, and needs in identifying his SAPs. If this team discussion was representative of the majority of treatment team discussions concerning the selection of individual's SAPs at LSSLC, then the major barrier to achieving substantial compliance with this provision item would be to ensure documentation of the discussions that are occurring. In order to achieve substantial compliance for this provision item, LSSLC needs to ensure that all assessments of individuals' preferences, strengths, skills, and needs are completed at least 10 days prior to the ISP, and that there is documentation of how assessments were used to select the individual skill acquisition plans.	

#	Provision	Assessment of Status	Compliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	LSSLC continued to make progress on this provision item, however, more work, discussed below, is necessary before it will be in substantial compliance. QIDPs at LSSLC wrote monthly progress notes and summarized SAP data. Six months of SAP reviews were requested for five individuals. Twenty of the 24 SAPs reviewed had at least three months of data. Eighteen of those 20 SAPs (90%) indicated SAP progress. There was some evidence of data based decisions concerning the continuation, modification, or discontinuation of SAPs (e.g., Individual #117's SAP to identify community signs, Individual #74's toothbrushing SAP), however, several SAPs appeared to achieve their behavioral objective, but training continued (e.g., Individual #337's showering SAP, Individual #43's SAP to learn to wait for staff to walk). One possible reason that SAPs continued beyond when they achieved their behavioral objective was that monthly SAP data were not graphed. The graphing of monthly SAP data would be one way to increase the likelihood that data based decisions concerning the continuation, discontinuation, or modification of skill acquisition plans consistently occurs. As in past reviews, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. One SAP observed (Individual #515's SAP of applying lotion), appeared to be conducted as written. This represented an improvement from the last review when 33% of the SAPs observed appeared to be implemented as written. Since the last review, LSSLC began to conduct SAP integrity sessions to ensure that SAPs were implemented as written. The monitoring team reviewed the SAP integrity tool and observed a SAP integrity session. The SAP integrity tool consisted of a direct observation of staff conducting SAPs and seven questions concerning the training across various components of SAP training (e.g., task analysis, consequences of corrects and incorrect responses, data collection, etc.). The monitoring team found the SAP integrity tool and process to be a good example of how to ensure that SAPs are implemented as written	Noncompliance

#	Provision	Assessment of Status	Compliance
		across the facility. The self-assessment indicated that 128 SAP integrity sessions were conducted in November 2013. The monitoring team was encouraged by the LSSLC's commitment to ensure that SAPs are consistently implemented as written. At this point, it is recommended that the facility establish a schedule of SAP treatment integrity assessments, ensure that SAP integrity is assessed in all treatment sites across the facility, determine acceptable levels of SAP integrity, and provide performance feedback to staff to ensure that goal levels of SAP integrity are achieved. In order to attain substantial compliance, the facility needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAP integrity attains established levels.	
	(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. For the reasons discussed below, however, this item was rated as in noncompliance. A spreadsheet provided to the monitoring team 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 the majority of individuals had training opportunities the community. This documentation did not, however, differentiate general training opportunities from training on individual SAPs. It is recommended that the facility ensure that the facility reorganize the training data so that specific SAP training in the community is documented. Additionally, it is recommended that LSSLC 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 the same as the last report when three individual were 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: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments o LSSLC facility-specific policies regarding most integrated setting practices • Client Management-38, Most Integrated Setting Procedures, 11/1/13 o LSSLC Training roster for facility-specific policy, 14 pages, 11/6/13 o LSSLC organizational chart, undated, but likely November 2013 o LSSLC policy lists, 11/26/13 o List of typical meetings that occurred at LSSLC, undated but likely November 2013 o LSSLC Self-Assessment, 12/30/13 o LSSLC Action Plans, 12/28/13 o LSSLC Provision Action Information, 12/16/13 o LSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/13/14 o Community Placement Report, last six+ months, 7/1/13 through 1/10/14 o List of individuals who were placed since last onsite review (9 individuals) o List of individuals who were referred for placement since the last review (22 individuals, plus 2 during the week of the onsite review for a total of 24) o List of individuals who were referred and placed since the last review (3 individuals) o List of total active referrals (17 individuals, plus two during the week of the onsite review for a total of 19) o List of individuals who requested placement, but weren't referred (0 individuals) • Documentation of activities taken for those who did not have an LAR (not applicable) • Those who requested placement, but not referred due to LAR preference (not applicable) o List of individuals who were not referred solely due to LAR preference (no data) o List of rescinded referrals (10 individuals) • ISPA notes regarding each rescinding (10 of the 10) • Special Review ISPA Team minutes for each rescinding (0 of the 10) o List of individuals returned to facility after community placement (1) • Related ISPA documentation (0 of 1) • Root cause analysis (0 of 1) 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 • 3 of 21 individuals who moved since 1/1/13

	o Completed Potentially Disrupted Community Transition forms (3) o List of individuals who died after moving from the facility to the community since 7/1/09 (3, 1 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (2 individuals) o APC Department meeting minutes, (none) o List and job descriptions for APD staff o APC weekly reports • Detailed referral and placement report for senior management, (5) • Statewide one page weekly enrollment report (0) o Variety of documents regarding education of individuals, LARs, family, and staff: (not reviewed) • Provider Fair • Community tours • Work with local LA • Work with local providers • Facility-wide staff trainings/activities • For families • Brochure and facility newsletter • CLOIP and PP tracking tools o Description of how the facility assessed an individual for placement (not reviewed) 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), (not reviewed) o APC's referral packet checklist o List of individuals who had a CLDP completed since last review (9) o DADS central office written feedback on CLDPs (0) o QA related activities and documents (not reviewed) o Set of 8 graphs, data through November 2013 o State obstacles report and SSLC addendum, (not reviewed) o PMM tracking sheet o Documentation of day of move items (0) o Supplemental information regarding LA involvement, gaps in CLDP describing activities, missing CLDP initiation dates o Transition T4 materials for: • (none reviewed) o ISPs for: • (none) o Pre-ISP draft used during the pre-ISP meeting: • Individual #151 o Draft ISP used during the ISP meeting: • Individual #418

	o CLDPs for: • Individual #146, Individual #292, Individual #505, Individual #23, Individual #226, Individual #412, Individual #138, Individual #216, Individual #302 o Draft CLDP for: • Individual #457 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 #431: 45, 90 • Individual #263: 45, 90 • Individual #340: 45, 90 • Individual #490: 45, 90, and post-90 • Individual #99: 45, 90 • Individual #257: P, 7, 45, 90 • Individual #216: P, 7, 45, 90, and post-90 • Individual #302: P, 7, 45, 90, and post-90 • Individual #138: P, 7, 45, 90, and post-90 • Individual #412: P, 7, 45, 90 • Individual #226: P, 7, 45 • Individual #23: P, 7, 45 • Individual #505: P, 7, 45 • Individual #292: P, 7 • Individual #146: P, 7 <u>Interviews and Meetings Held</u>: o Lisa Pounds Heath, Admissions and Placement Coordinator o Mary Martin Ramsey, Post Move Monitor o Leigh-Ann Thomas, Placement Coordinator, Cynthia Thigpen, Transition Specialist, Amanda Huckabee, Transition Specialist o Community provider agency: St. Giles Homes, management and group home staff <u>Observations Conducted</u>: o CLDP meeting for: • Individual #457 o ISP and pre-ISP meetings for: • Individual #151, Individual #418 o Community group home visit for post move monitoring for: • Individual #138 o Senior management meeting/IMRT, referral review, 1/15/14

	Facility Self-Assessment The APC self-rated T1a, T1b, T1b1, T1b2, T1c, T1c1, T1c2, T1c3, T1e, T1h, T2a, and T4 in substantial compliance (i.e., 12 provision items). Of these 12, 2 were predetermined to be in noncompliance based upon an agreement between the parties and the Monitor (T1b1, T1b2) and 4 were predetermined to be in substantial compliance (T1c2, T1c3, T1h, and T4). Of the remaining 6, the monitoring team agreed with 2 (T1c, T2a). The monitoring team did not agree with T1a and T1c1 because not all of the metrics were met, with T1b because there were no facility-specific policies, and with T1e because the list of pre and post move supports did not meet criterion. On the other hand, the monitoring team found T2b to be in substantial compliance. The facility did not self-rate T2b, but could, based upon the APC's actual observation of the PMM's implementation of post move monitoring. As indicated in previous monitoring reports, the self-assessment's over reliance on the three statewide monitoring tools and failure to include all of the aspects of section T that the monitoring team looks at competed with the validity of the self-assessment and with its correlation with the findings of the monitoring team. Fortunately, DADS recently issued a statewide set of new self-assessment tools for section T. The monitoring team observed implementation of the CLDP tool. The APD staff used the tool to observe a CLDP meeting, however, to the monitoring team, the tool seemed designed to assess the completed CLDP document, not the CLDP meeting. The APC might review this so that she and her staff do not use a tool that is not valid for a CLDP meeting. Moreover, other tools typically used by LSSLC and other SSLCs were not used during the preparation for this review. These were the action plans and PAI documents. These are not required by the monitoring team or by the Settlement Agreement, however, they have been helpful to the facility in the past.
	Summary of Monitor's Assessment LSSLC made progress in some areas of section T, primarily in the quality of post move monitoring implementation and documentation, as well as in the continued transition and placement of individuals into the community. All of the admissions and placement department staff remained the same, plus there was the addition of one new placement coordinator position, bringing the total number of staff to five. Five provisions remained in noncompliance based upon an agreement between the parties and the Monitor made in the weeks prior to the onsite review due to self-reported lack of progress (T1b1, T1b2, T1b3, T1g, T1h). On the other hand, also based upon this agreement, four others remained in substantial compliance due to their substantial compliance status for a number of consecutive reviews (T1c2, T1c3, T1h, T4). The monitoring team found a number of processes and documentation problems remained identical to what was found during the last review. That is, the department took no action to make these improvements, such as in CLDP pre and post move support lists

	9 individuals had been placed in the community since the last onsite review. 19 individuals were on the active referral list. Of the 21 individuals who moved in the past 12 months, 3 were reported to have had one or more untoward events that occurred within the past six months (14%). Of these 3, 2 (67%) were successfully resolved or managed. The facility and DADS proposed no monitoring, for some provisions because they were acknowledged to be in noncompliance before the initiation of this onsite review. Thus, the most integrated setting practices related to ISPs, professional assessments and determinations, education of individuals and their LARs and staff, quality assurance, and obstacle identification and actions were not monitored during this review. CLDPs were developed for each individual who was referred. A CLDP meeting was conducted during the onsite review and was observed by the monitoring team. It was a good, lively meeting, with lots of participation from the individual and most attendees. More information and detail regarding the training of provider staff, and preparation of the provider were necessary (T1c1). Discharge assessments were completed for all relevant disciplines, however, they did not focus upon the needs of the individual in his or her new setting and how supports might be provided in the new home and day settings. The lists of pre-move and post-move supports were identified in the CLDPs. More work was needed to ensure that these lists were comprehensive and worded in measurable, verifiable terms (T1e). Post move monitoring continued to be implemented as required and maintained substantial compliance. 33 post move monitorings for 15 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed up when action was needed.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of	<u>Placement Department Staff</u> The admissions and placement department (APD) continued to be led by Lisa Pounds Heath, the Admissions and Placement Coordinator (APC). She held this role for many years and was knowledgeable of the requirements of section T, placement processes, each of the individuals who had been placed, and each individual who was on the active referral list. Three other staff remained in the same positions: the Post Move Monitor (PMM) was Mary Ramsey, and the Transition Specialists were Cynthia Thigpen and Amanda Huckabee. The APD added one new position, a Placement Coordinator. The facility hired Leigh-Ann Thomas for this position.	Noncompliance

	professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Five provisions remained in noncompliance based upon an agreement between the parties and the Monitor made in the weeks prior to the onsite review due to self-reported lack of progress (T1b1, T1b2, T1b3, T1f, T1g). On the other hand, also based upon this agreement, four others remained in substantial compliance due to their substantial compliance status for a number of consecutive reviews (T1c2, T1c3, T1h, T4). The facility continued to maintain a transition home for individuals who were referred and for whom their IDT recommended this interim step. Further, all new transfers to any of the Circle Drive homes required that the individual be referred to the community thereby essentially making all of the Circle Drive homes transition homes for those who lived there, except for the handful of individuals who were already living there prior to this new requirement. <u>Transition-Related Numbers</u> Transitions: • The number of individuals placed was at an annual rate of about 5%. 9 individuals had been placed in the community since the last onsite review. This compared with 16, 7, 8, 13, 9, 8, and 5 individuals who had been placed at the time of the previous monitoring reviews. o The number was similar to that at the time of the previous reviews and showed continued referral, transition, and placement activity. Referrals: • 24 individuals were referred for placement since the last onsite review. This compared with 19, 15, 7, and 14 individuals who were newly referred at the time of the previous reviews. o 3 of these 24 individuals was both referred and placed since the last onsite review. • 19 individuals were on the active referral list. This compared with 14, 18, 13, 17, 20, 25, and 17 individuals at the time of the previous reviews. o 1 of the 19 individuals was referred for more than 180 days. This compared to 3 at the time of previous reviews. ▪ 1 of the 1 was only a few days past 180 days. His placement activities were slowed due to illness, but he had re-engaged with transition activities, including attending a pre-placement visit during the week of the onsite review. ▪ 0 of the 19 individuals was referred for more than one year. This compared to 0 at the time of the previous review. Potential negative outcomes (compliance is addressed in T1f, however, given that T1f was found to be in noncompliance based upon the agreement between the parties and the Monitor, the monitoring team has provided some commentary here)	

		• 1 individual returned to the facility after community placement. This compared with 1, 0, 0, 0, and 2 individuals at the time of previous reviews. • 1 individual had died since being placed since the last onsite review. This compared with 0, 0, 0, 0, 0, and 2 at the time of previous reviews. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, who had run away from their community placements, and/or had other untoward incidents continued to be tracked. These data were being obtained for a one-year period after moving. o Of the 21 individuals who moved in the past 12 months (and for whom information was available), 3 were reported to have had one or more untoward events that occurred within the past six months (14%). Two of the 3 (67%) were satisfactorily resolved for the individual. o There was a new statewide system and form for reporting these types of events, and for helping the APC to review these events. It was called the Potentially Disrupted Community Transition form. The monitoring team reviewed three examples. Overall, the format helped guide a review of the case. It did not, however, address what might be done to improve transition services for individuals at the facility. ▪ All cases should be reviewed 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. ▪ The PDCT form should be updated to prompt this type of discussion. ▪ Based upon one of the incidents, the APC now included a standard post-move support that the facility be immediately notified of any of these untoward events. Alternate discharges (compliance is addressed in T4) • 1 individual was discharged under alternate discharge procedures. <u>Determinations of professionals</u> Professional members of the IDT are required to state their opinion regarding the most integrated setting for each individual in their annual assessments, during the ISP meeting, and in the written ISP document. Compliance is addressed in T1b3. <u>Placement and referral not opposed</u> a. In reviewing the CLDPs and ISPs for 12 individuals who were on the referral list or who had been placed, 12 (100%) individuals and/or LARs did not oppose transition to the community.	

		• The facility, however, reported that family members or advocates for 4 of the individuals were opposed to the move and, as a result, a resolution committee, headed by the facility director, was going to be conducted for each. None of these family members or advocates was currently the LAR for the individual. <u>Responding to individual requests and rescinded referrals</u> There were 10 rescinded referrals since the last review. This compared to 6, 3, 3, 4, and 4 at the time of the previous reviews. Documentation (ISPA notes) was provided for 10 of the 10 individuals regarding the reasons for the rescinding. b. Of these 10, the reasons for the rescinding appeared to be reasonable for 10 (100%). Further, an adequate review to determine if changes in the referral and transition planning processes at the facility was conducted for 0 (0%) of the rescinded referrals. Of these reviews, actions were recommended in n/a cases. Of these, actions were implemented for n/a (--%). • Three were rescinded due to LAR preference (one of which was to move to another state). • Two were for increases in problem behaviors at the facility (aggression, inappropriate sexual behaviors, pulling out g-tube). • Three were rescinded because a provider could not be found who could meet the challenging medical and physical needs of the individual. • Two were rescinded because of serious problem behaviors that occurred during the pre placement visits. The rescinding of a referral should not be considered a failure and should not deter IDTs from referring individuals. Two of the ISPAs briefly mentioned what might be done if the individual was referred again at a later time. A review for quality improvement purposes, however, should be conducted for all 10. 0 individuals were described as having requested placement, but were not referred. This compared with 2, 2, 8, 6, 6, and 9 individuals at the time of the previous reviews. The list of individuals not being referred solely due to LAR preference contained more than 100 names. This compared to 0, 38, 107, 6, 3, and 17 individuals at the time of the previous reviews. This was not an accurate count and needs to be completed correctly by the facility. c. Of the 0 individuals who requested placement, but were not referred, n/a individuals had an LAR who made this decision. Of the remaining n/a individuals, an appropriate review, appeal, and or lack of consensus review was conducted for n/a (%). (not applicable)	

		Systemic issues d. There were not systemic issues delaying referrals (at the state and/or facility level). If there were any, there (were/were not) actions being taken to resolve them. (not applicable) e. There were existing and/or potential systemic issues delaying transitions (at the state and/or facility level). • Two issues were identified during the onsite review: (a) an absence of providers who can support individuals with challenging and multiple medical and physical needs, such as lifts, transfers, and nursing care, and (b) an absence of enough providers in Lufkin to support the many individuals who had come to know Lufkin and preferred to stay in Lufkin. • There were not actions being taken by the facility to resolve them. f. Funding availability was cited as a barrier to individuals moving to the community. Specifically, the need for additional staff for lifts, transfers, and safety was cited as a cost barrier. g. Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. The APC continued to do an outstanding job of this each week at an IMRT meeting. Pace of transitions h. Transitions were occurring at a reasonable pace (i.e., metrics i., j., and k. below met criteria). 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 the 9 individuals placed since the time of the last onsite review, 5 (55%) were placed within 180 days of their referral (i.e., 4 were not). • At the time of the review, 19 individuals had been referred for community transition. 1 of these 19 individuals had exceeded the 180-day timeframe. o Of these, 0 individuals had exceeded one year. i. Reasonable activity and actions had occurred related to the transition and placement for 5 of the 5 (100%) individuals. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for 5 of the 5 (100%) individuals.	

		k. Adequate justification was provided for the lengthier transition process for 5 of the 5 (100%) individuals. A thoughtful transition was planned, and implemented for Individual #216. Additional supplemental information was provided by the APC; in the future, this information should be included within the CLDP, most likely in section IV-B.	
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:	<u>State policy</u> a. The state policy for most integrated setting practices was recently issued. The monitoring team will comment at the next compliance review as to whether the state policy adequately addressed all of the items in section T of the Settlement Agreement. <u>Facility policy</u> b. There were not facility policies that supported the state policy for most integrated setting practices. LSSLC's facility policy was merely the state policy with "LSSLC" inserted to replace the words "state center." Instead, the facility should have policies and procedures that operationalize/define implementation of the parts of the state policy that are not specific. For this policy, examples include (but are not limited to) the way in which community tours are managed, how educational activities are presented to individuals, how the admissions and placement department staff ensure that all supports and services are included in CLDPs, how the PMM conducts post move monitoring, and which staff are to review the CLDP prior to its submission to the facility director. 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	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

	with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.		
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC submitted 9 CLDPs completed since the last review. This was 100% of the CLDPs completed in that period. The CLDPs were in the newer format, which the monitoring team found easy to read. The monitoring team reviewed 5 of the 9 (55%) CLDPs in depth. <u>Timeliness of CLDP</u> Initiation of CLDP a. 5 of the 5 (100%) CLDPs were initiated within 14 calendar days of referral. This was called the CLDP Profile date. Ongoing development of CLDP b. 5 of the 5 (100%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process.	Substantial Compliance

		<u>IDT member participation in placement process</u> c. 5 of the 5 (100%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., 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). <u>Coordination of CLDP with LA</u> d. 5 of the 5 (100%) CLDPs or other transition documentation 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 and the provision of provider lists. 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. This information was provided to the monitoring team in a supplemental document; in the future, it should be included in the CLDP, perhaps in section IV-B.	
	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. <u>The CLDP specifies actions to be taken by facility</u> a. 0 of the 5 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 of the activities listed below, in the six closed 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 (0%). The LSSLC CLDPs, same as last time, had a single standardized support that new staff would be trained on <u>all</u> of the aspects of the individual's support needs. Instead, the CLDP should indicate: i. who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), ii. the method of training (e.g., didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP), and iii. a competency demonstration component, when appropriate. • Collaboration with community clinicians (e.g., behavioral health specialists and psychologists, PCP, SLP). This was noted in four of the CLDPs (80%) for one or two clinicians: nurse to nurse (Individual #146, Individual #505, Individual #226), psychiatrist to psychiatrist, and behavioral health specialist/psychologist to psychologist (Individual #138). For other clinicians and for the other individuals, either this type of contact was not	Noncompliance

		arranged when it should have been, or it was perhaps deemed not necessary. The CLDP should indicate this decision. • Assessment of settings by SSLC clinicians (e.g., OT/PT). This occurred somewhat for Individual #505 (20% of individuals) in that the CLDP indicated that some modifications, such as new flooring, were needed, but the CLDP did not indicate if it was a habilitation clinician who was involved in this action. • Collaboration between provider day and residential staff . This was not evident in any of the CLDPs (0%). • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not evident in any of the CLDPs (0%). If not needed, this should be indicated in the CLDP. • Collaboration between Post-Move Monitor and Local Authority staff. This may likely have been occurring, but was not noted in any of the CLDPs. <u>Documentation of day of move activities</u> b. 5 of the 5 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. In the last few months (i.e., the most recent CLDPs) documentation that the activities did indeed occur was included in the pre move site review as pre move supports. Even if the pre move site review was conducted a few days or a week before the actual move, the PMM or one of the APD staff, ensured that the items were indeed transferred on the day of the move; this was then documented in the pre move site report and in the 7-day report. This was evident in the post move monitoring reports for the four individuals who most recently moved to the community (i.e., Individual #146, Individual #292, Individual #505). <u>CLDP meeting prior to moving</u> A CLDP meeting occurred for 5 of the 5 individuals (100%). It was described in each of the CLDPs c. During the CLDP meeting observed during the onsite review, an adequate and complete CLDP meeting was conducted for Individual #457. The monitoring observed the occurrence of the following activities (except for items 2 and 3, which could not be determined during the meeting). • Attendance by all relevant IDT members, community providers, and LA • Individual preparation occurred prior to the CLDP meeting, if appropriate to do so • DSP preparation occurred prior to the CLDP meeting, if appropriate to do so • Individual participation occurred, or was facilitated, if needed • There was active participation by team members • All relevant pre-move and post-move (essential/nonessential) supports	

		were discussed and any issues resolved • The post-move monitor actively participated to ensure that supports were adequately defined and required evidence specified.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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. The following review was based on a sample of assessments from 5 of the CLDPs. <u>The assessments selected for completion are appropriate and none are left out</u> a. For 5 of the 5 CLDPs reviewed (100%), all necessary assessments were completed. <u>Assessments done within 45 days of move date</u> b. For 5 of the 5 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. <u>Assessments are available for use by the APC and IDT</u> c. For 5 of the 5 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. <u>Assessments are of adequate quality</u> d. For 0 of the 5 CLDPs reviewed (0%), the assessments were of adequate quality based upon the following: • A summary of relevant facts of the individual's stay at the facility. o The content of the assessments for most of the assessments for all 5 individuals contained relevant facts regarding the individual's stay at the facility. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o Most of the assessments for all 5 individuals were thorough enough	Noncompliance

		to assist teams in developing a list of supports. Some, however, were extremely short (e.g., dental) and some were extremely long (e.g., speech). Full assessments accompany each discharge, therefore, discharge assessments should be designed specifically to help the team develop supports and to help the new provider to provide those supports. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. o The assessments for 0 of the 5 individuals specifically focused on the new home or day settings. • 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. o The assessments for 0 of the 5 individuals specifically focused upon how the necessary supports might need to be provided in these new settings. The APC reported that many of the disciplines (e.g., QIDP, nursing, medical) had new formats for writing discharge assessments that would likely be more in line with the requirements of this provision. See section M of this report for more detail on problems with nursing discharge summaries. The monitoring team suggests that the APC develop a tool to self-monitor the quality of discharge assessments. It should look at the quality by directly assessing the above four open bullets.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the	The lists of pre-move and post-move supports were identified in the CLDPs. <u>Pre- and post-move support lists are adequate</u> a. In 0 of the 5 CLDPs reviewed (0%), a comprehensive set of essential and nonessential supports was identified in measurable/observable terms. This finding was based on the following three numbered bullets. Overall, the status of the list of supports maintained from the last onsite review and surprisingly all of the comments made in the last report still applied. There was one exception: the post move monitoring evidence descriptions had improved. 1) The list is comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This applied to 3 of the 5 individuals. The comments made in the previous report still applied, that is, same as last time, the supports provided no detail as to what was important about the	Noncompliance

	implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	PBSPs that needed to be implemented. Merely saying to continue to implement the BSP was insufficient. This was also evident in the CLDP meeting for Individual #457. o All safety, medical, healthcare, therapeutic, risk, and supervision needs were addressed. ▪ This applied to all 5 individuals. Many health-related supports were included, such as regarding adaptive equipment and diet textures. The monitoring team, however, found that some health-related conditions were not adequately addressed for 3. These were detail on potassium and phosphorous diet issues (Individual #146), head of bed elevation, history of vomiting, g-tube replacement, and "altered mental status" (Individual #505), and kidney, urination, and blood pressure problems (Individual #226). Many individuals were noted to have oral hygiene problems, but these were not addressed in the support lists. Further, there was nothing about obtaining guardianship for some of the individuals who either had a lapsed guardianship or were in need of guardianship. This applied to all 5 of these individuals. o What was important to the individual was captured in the list of pre- and post-move supports. ▪ This applied to all 5 and was adequately addressed for all 5. o The list of supports thoroughly addressed the individual's need/desire for employment, and/or other meaningful day activities. ▪ Employment supports did not apply to any of the 5 individuals. Two attended school and the other 3 did not work. The CLDPs, however, adequately addressed their need for school and day habilitation attendance. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of pre- and post-move supports. ▪ This was not addressed in any of the CLDPs. Positive reinforcement applied to all individuals, but certainly for the three individuals who had PBSPs. o There were pre-/post-move 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 included for all 5. For 3 of the 5, however, same as last time, the CLDP listed the skills, but said "informal or formal." It would be better to indicate which were to be taught formally. The monitoring team was surprised at the lack of formal training supports to improve communication skills.	

		o There were pre-/post-move supports for the provider's <u>implementation</u> of supports. That is, the components of the BSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue are included. o All recommendations from assessments are included; or if not, there is a rationale provided. ▪ For the most part, recommendations were included. When they weren't, there was no rationale provided. Examples were psychology's recommendation for physical activity for Individual #505 and some of the medical and nutritional recommendations for Individual #412. 2) The wording of every pre-/post-move support is in measurable, and observable terms. o Many were in measurable terms, however, many continued to include words, such as "assistance," "opportunity," and "access." 3) Every pre-/post-move support included 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. o This was much improved and included references to checklists, data, data sheets, interviews, and direct observation. Still needed, however, was a criterion, where appropriate. To improve, the monitoring team recommends that the APC create a self-assessment for the pre- and post-move support section of the CLDP. She can use the above items to create this checklist for herself and her staff. <u>Essential supports were in place on the day of the move</u> b. For the 5 of 5 (100%) CLDPs reviewed for individuals who were placed, a pre-move site review was conducted by the facility. c. Of these 5, 5 (100%) were done timely and completely. d. Of these 5, 5 (100%) indicated that all of the essential supports were in place prior to the individual's move, or if they were not, identified the issue and showed that action was taken to remedy the situation. • The PMM (or whomever conducts the PMSR) should provide detail indicating if all of the aspects detailed in the CLDP regarding <u>training</u> occurred as per the CLDP, such as who, what, how, and documentation of competency. e. For___ of __ (%) pre-move site visits observed by the monitoring team (if any), the pre-move site visit was conducted thoroughly. (none observed by the monitoring team)	

T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall	The parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

	issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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	LSSLC maintained substantial compliance with this provision item. Since the last review, 33 post move monitorings for 15 individuals were completed. This compared with 36 post move monitorings for 18 individuals, 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 reviewed completed documentation for 33 (100%) post move monitorings for 15 different individuals. Of the 33 post move monitorings, all but 1 were completed by the post move monitor Mary Ramsey.	Substantial Compliance

	supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of Visits</u> For the 15 individuals, 33 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team and by the post move monitoring reports, of the 33 required visits, 33 (100%) were conducted and 33 (100%) were completed on time. Of the 33 post move monitoring forms reviewed by the monitoring team, all 33 (100%) included dates showing that they were completed on time. <u>Locations visited</u> For the 33 post move monitorings reviewed, 33 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment; no individuals attended public school) were visited. <u>Content of Review Tool</u> 33 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. 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 23 of the 23 (100%) 45- and 90-day visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 33 of the 33 (100%, all but Individual #133, 7-day). o The PMM should now provide detail in her report regarding whether she had evidence of all aspects of required training, such as who, what, how, and documentation of competency. o It would be helpful to the reader and IDT if the PMM could specify what documentation she looked at, whom she interviewed, and what she observed rather than just saying interview, observation, and review of documentation. • There was adequate justification for findings for each support in 33 of the 33 (100%). • Detail/comment was included in 33 of the 33 (100%) reports for most every support. • LAR/family satisfaction with the placement and the individual's satisfaction were explicitly stated in 33 of 33 (100%). • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements was provided by the PMM at the beginning of the report in 33 of the 33 (100%). The PMM did a very good job of writing these summaries.	

		Additionally: a. 23 of 33 reports (70%) indicted the specific name and title of each person interviewed by the PMM. The reports missing the names were in the early part of the six month review period. By the middle of the review period, the PMM was including this in all reports (i.e., the most recent 14 of 14 [100%]). b. Compared to the last review, there were more instances of the PMM specifically requiring (and receiving) checklists from providers regarding staff implementation of support actions. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 15 individuals who received post move monitoring, 14 (93%) transitioned very well and appeared to be having good lives. One of the 15, had some medical and behavioral challenges that were still not being met (Individual #302). 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. <u>Use of Facility's best efforts when there are problems that can't be solved</u> In 20 of the 33 post move monitorings (61%), additional follow-up, assertive action, and activities were required of the post move monitor. These were for 11 of the 15 individuals (73%). Most of the problems (15 of the 20) were of a moderate level, such as a magazine subscription, communication with family members, and appointments. There was appropriate follow-up and correction for 15 of these 15 (100%) visits for 9 of 9 individuals (100%). Follow-up was done in a timely and thorough manner. For the other 5 issues, for 2 of the individuals, the issues were much more serious and involved absence of care, neglect, supervision and safety issues, and lack of providing a safe and clean environment. The PMM was tenacious in following up, involving the IDT, informing the APC, informing DADS state office (with the APC), reporting to DFPS, conducting additional onsite visits, requiring documentation, and phone calls. This was done for Individual #302 and Individual #138. Due to the PMM's actions, supports were provided to individuals that may not have been provided, safety was addressed, and additional assistance was obtained when needed (e.g., IDT, APC, and state office involvement). This was the intent of the this provision of the Settlement Agreement. <u>ISPA meetings after post move monitoring visits</u> 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 13 out of 13 (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 #138 for the post-90-day review and at the office of the provider. 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 St. Giles. Due to previous problems in support provision, a post-90 post move monitoring was conducted. The PMM reviewed every support from the CLDP, not only those with which there were problems. Further, the home was dirty, much of the furniture and cabinets were worn, and the ceiling needed cleaning from vent air.	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 parties agreed the monitoring team would not monitor this provision, because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

SECTION U: Consent	

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain 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	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.		

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 (no changes): • Recordkeeping Practices, Adm-15, updated 6/4/13 • Management of Protected Health Information, Adm-3, updated 2/1/13 o LSSLC organizational chart, undated, but likely November 2013 o LSSLC policy lists, 11/26/13 o List of typical meetings that occurred at LSSLC, undated but likely November 2013 o LSSLC Self-Assessment, 12/30/13 o LSSLC Action Plans, 12/28/13 o LSSLC Provision Action Information, 12/16/13 o LSSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/13/14 o List of all staff responsible for management of unified records o Description of changes since the last onsite review (there weren't any changes) o List of other binders or books used by staff to record data (there weren't any) o Description of the LSSLC shared drive o Tables of contents for the active records (updated 11/20/13), individual notebooks (updated 11/13/13), and master records (no changes) o Description of how LSSLC addressed the previous report recommendations for V1 o Database of all state and facility policies with training information, 52 pages, 1/2/14 o Database showing state policies/Settlement Agreement sections in full database, 1/15/14 o Description of the unified record audit process o Blank unified record audit tool, 26 pages (updated 9/20/13) o List of individuals whose unified record was audited by the record clerks and by the URCs, June 2013 to November 2013 o Completed audits for 10 individuals (record clerk audits), October 2013 and November 2013 • Completed unified record audit and guidelines tool, • Findings list • One V4 interview of an IDT member • Emails showing notification of relevant staff o List of individuals whose record audits received an inter rater agreement review, June 2013-November 2013 (11), and list of who did the inter rater review for 4 of the 11 o One completed inter rater tool o Set of six graphs of audit results, June 2013 through December 2013 o Additional emails to department heads regarding corrections needed and/or problems identified

	as a result of the unified record audits o Description of how LSSLC addressed the previous report recommendations for V3 o Packet of 15 email chains and 2 record clerk meeting agenda showing various and ongoing addressing of recordkeeping practices, July 2013 through November 2013 o QA report for section V (none, also no data from any QAQI Council minutes)) o Packet of information describing how LSSLC addressed all six components of section V4 (none) o Description of how LSSLC addressed the previous report recommendations for V4 o URCs' responses to the onsite review questions posed by the monitoring team 1/21/14 o Active records and/or individual notebooks of: • Individual #20, Individual #221, Individual #406, Individual #519, Individual #339, Individual #529, Individual #188, Individual #469, Individual #401, Individual #374, Individual #111, Individual #311 o Master records of: • Individual #212, Individual #371, Individual #111 <u>Interviews and Meetings Held</u>: o Stormy Tullos and Terri Fatheree, Unified Records Coordinators o Various DSP staff <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area o CLDP, ISP, and pre-ISP meetings; clinic meetings; PNMT meeting
	Facility Self-Assessment The self-assessment for V1 correctly used data from the V3 quality assurance audits to help make the self-rating of substantial compliance for V1. The self-assessment would be better, however, if, in addition, it contained all of the sections and items that the monitoring team includes in the monitoring report. The self-assessment for V2 would benefit by separating out the state and facility policies for each of the provisions of the Settlement Agreement from the other policies that are LSSLC-specific. Further, the self-assessment should include a report of the different areas (columns) on Ms. McHenry's spreadsheets (e.g., percentage of state policies for which more than 90% of the staff required to be trained, were trained). For V3, the self-assessment included all of the important components, except it would be better if it also included was trending done, was analysis completed, were actions developed and implemented, etc. The V4 self-assessment should report on all six of the areas that the monitoring team assesses for V4. This self-assessment reported on actions taken for all six items (this was good to see), but did not report on the outcomes/data for all of them.

	The facility self-rated itself as being in substantial compliance with V1, V3, and V4, and in noncompliance with V2. The monitoring team agreed with these self-ratings for V1, V2, and V3, but not for V4. Detail is in the report below.
	Summary of Monitor's Assessment: The recordkeeping department maintained substantial compliance with provision V1 and achieved substantial compliance with V3. Progress was seen in provisions V2 and V4. Twelve of 12 (100%) individuals' records reviewed included an active record, individual notebook, and master record. 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. Individual notebooks continued to be used for all individuals and as per state policies. A master record existed for every individual at LSSLC. Overall, the master records were in good shape. The new "Policy and procedure tracking database" included information on state policies, facility policies, the relationship of policies to Settlement Agreement provisions, review dates, revision dates, QAQI Council approval status, and staff training information. The QA director reported that they now had a process for meeting this provision, but it was new and not all policies had yet gone through the review, approval, and training steps. Five (or more) reviews (audits) were conducted in each of the previous six months. Thirty-two reviews were conducted at LSSLC in the six-month period June 2013 through November 2013. All of the reviews were done in a fairly consistent manner, and were neatly and clearly documented. Inter-rater agreement reliability checks were occurring regularly over the past six months. The URCs and data analyst improved upon their set of graphs from the time of the last review. This set of graphs adequately showed trending regarding the important data for their recordkeeping practices. The facility was in substantial compliance with three of the six items (50%) of section V4.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the	LSSLC again continued to make good progress on all four of the items of provision V. The recordkeeping department at LSSLC maintained substantial compliance with this provision and achieved substantial compliance with V3. Progress was seen in provisions V2 and V4.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	guidelines in Appendix D.	Recordkeeping activities continued to be lead by the unified record coordinators (URC) Stormy Tullos and Terri Fatheree. They were part of the QA department, Paula McHenry QA director. Ms. Tullos and Ms. Fatheree took very seriously the comments in the previous monitoring report and made numerous improvements in the facility's recordkeeping practices since the last review. Moreover, improvements and attention to recordkeeping practices occurred throughout the past six months. In addition, the URCs sought out and worked with various discipline heads when needed. The facility maintained the same five record clerks as during the previous review. This stability served the facility's recordkeeping practices very well. In addition to their regular record management activities, record clerks continued to do end-of-month late night document transfers, conduct a monthly audit of another record clerk's unified record, and attend periodic record clerk meetings. The ongoing attention to improvement in quality of recordkeeping practices was evident in the content of two record clerk meetings/inservices and in the 15 email chains given to the monitoring team. These covered a wide range of recordkeeping topics. State policy and facility-specific policies remained the same as in previous review. The active record and individual notebook tables of contents had some changes since the last review. These changes were in response to state updates or facility needs. Twelve of 12 (100%) individuals' records reviewed included an active record, individual notebook, and master record. <u>Active records</u> The status of the active records maintained since the last review. The monitoring team reviewed active records in each of the four units at LSSLC. 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 monitoring team's onsite review of active records showed approximately three errors/missing documents per active record. This was similar to what was found by the record clerks and URCs in their own audits. The monitoring team met with the URCs after conducting the onsite reviews of the unified record and reported each of the documents that were missing from the active records that were reviewed. The URCs then checked these records and reported back to the monitoring team on how each missing item would be corrected or, in a few cases, that the item wasn't missing, it was instead misfiled or attached to another document.	

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		The overall number of errors found by the record clerks and URCs included some error categories not assessed by the monitoring team. This, however, was good to see and the facility's audits should definitely continue in the same manner as they have been doing them. The URCs successfully addressed the comments, suggestions, and recommendations in the previous monitoring report, and engaged in other activities towards the continuous improvement of the quality of the active records: • Continuation of audits, feedback, and follow-up, as per section V3. • Improvements in nursing entries/eligibility were addressed with the NOO. • Record clerks tracked the ISP for assessments and for quarterly ISP reviews. • URCs and record clerks met (on separate occasions) with the nursing NOO, director of behavioral health services, and director of the QIDPs. Topics included the infirmary, Reiss screens, and ISPs. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. Continuous quality improvement activities included: • Continuation of audits, feedback, and follow-up, as per section V3. • The example of one home's "paperwork checklist" was shared with all units. • Unnecessary items were removed from the individual notebooks. <u>Other binders/logs</u>: The facility reported that there were no other binders or logs used to record data regarding the individuals. <u>Master records</u> A master record existed for every individual at LSSLC. Overall, the master records were in good shape. The URCs continued the useful procedure of noting (in the comment section of each master record) the status of any missing documents and any activities engaged in to locate them. These notes/entries should be dated. One question that arose was whether it was sufficient to have a photocopy of the individual's birth certificate and social security card as compared to whether the original was required. The URCs should check with state office on the appropriate standard.	

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		Shared drive The shared drive status remained the same. That is, 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.	The progress described in the previous report continued. At this time, policies, policy status, and training information were maintained in a database that was now 52 pages long. It was created, updated, and managed by the QA director, Paula McHenry. This was a big improvement since the last onsite review. The database, called the "Policy and procedure tracking database," included information on state policies, facility policies, the relationship of policies to Settlement Agreement provisions, review dates, revision dates, QAQI Council approval status, and staff training information. Not all state policies were in place yet, though continued progress was evident (only provisions G and H did not have a state policy). In the QA director's subset database of the Settlement Agreement provisions, 16 of the 20 were represented (all except H, J, O, and Q). It may be that policies exist for these, but perhaps the proper code was not entered into the database and, therefore, the policies did not appear in the subset database. The QA director reported that they now had a process for meeting this provision, but it was new and not all policies had yet gone through the review, approval, and training steps. The monitoring team agreed and found the database to be comprehensive, though not yet complete.	Noncompliance
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	The URCs made a lot of progress in their quality assurance procedure program and implementation, including responding to the comments, suggestions, and recommendations in the previous monitoring report. The monitoring team found this provision to be in substantial compliance. Five (or more) reviews (audits) were conducted in each of the previous six months. Thirty-two reviews were conducted at LSSLC in the six-month period June 2013 through November 2013. All of the reviews were done in a fairly consistent manner, were reported to take about a full day to complete, and were neatly and clearly documented. The review consisted of four parts:	Substantial Compliance

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	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.	• Completed unified record audit and guidelines tool (26 pages) • Findings list • One V4 interview of an IDT member • Emails showing notification of relevant staff The base system remained the same as described in the past few monitoring reports. That is, the audits were conducted by the record clerks. There were five clerks, they each conducted one each month, and they audited one of the other record clerk's unified record (i.e., not their own). In addition, as recommended in the previous report, the URCs were also now doing one full audit each quarter. Thus, some months had a sixth or seventh audit conducted. The URCs' data were included in the department's overall data and findings. The detailed no-longer-new audit tool continued to be used. It was 26 pages long, with about a dozen items (lines) on each page, with 14 columns of criteria for each of the items (not all criteria applied for every item) for a total of more than 1,000 items being scored per review. The system of conducting the audit, listing all errors, emailing to the responsible person, following up on each error (with checks for corrections now occurring at one week and one month), and documenting the V4 interview continued in the same manner as described in some detail in previous monitoring reports. This continued to be a very good system that was easy to understand. The record clerks reported that they continued to use the medical consultation database to determine what medical consultation documentation should be in the active record, and they continued to use the ISP to determine what SAPs should be in the active record and individual notebook. It was good to see that this had continued. The new database, briefly noted in the previous monitoring report, was now in place. It allowed an assigned QA department program monitor to enter the record clerk and URC audit data directly into the database. The database then printed out tables and graphs. This was another nice improvement to their system. Examples of other improvements to the quality of the audit process included: • Because there were five record clerks and four units, each month, one unit had two audits conducted. The URCs rotated the doubling-up from unit to unit across consecutive months. • The recordkeeping staff ensured that no individual was re-audited within a 24-month period. In this way, as many individuals as possible could receive audits.	

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		• The URCs rotated which record clerk received an inter rater assessment, so that each would be checked across the year. • Record clerks and URCs were now sending complimentary positive email feedback to staff (i.e., rather than only emailing them when there were problems and/or corrections needed). Inter-rater agreement reliability checks were occurring regularly over the past six months. Eleven were conducted from June 2013 through November 2013. They were conducted by three trained members of the QA department. The entire unified record tool was completed by the QA staff member. The URCs reported, subjectively, that there was a lot of agreement. They now need to calculate a percentage to determine if the point-to-point reliability was actually at an acceptable level (i.e., calculate the percentage of items in which there was agreement between the record clerk and QA staff member). Moreover, if the level of agreement is high, they can do one per month rather than two per month. Inconsistency across record clerks (i.e., another version of inter-rater agreement reliability) was an issue raised in the previous two reports. To address this, the URCs held a record clerk inservice session on 9/18/13. Moreover, the URCs now reported data for each record clerk on a bar graph so that comparisons could be made. Since October 2013, their data showed less variability by record clerk. The URCs should continue to analyze these data each month because they only had one quarter of data so far. The URCs and data analyst improved upon their set of graphs from the time of the last review. This set of graphs adequately showed trending regarding the important data for their recordkeeping practices. Data points were graphed since June 2013 through December 2013. The first five graphs below were in line graph format, with larger data points, as recommended in the previous report. The data analyst and URC should consider graphing for a longer trend period than only the last six months, especially given that they now have almost a year's worth of data for some of these measures. The remaining six graphs were bar charts showing excellent detail of the error findings in a more drilled down manner (i.e., by unit, by record clerk). Below is a list of the graphs, with commentary and suggestions from the monitoring team. • Number of audits completed each month • Number of errors identified each month o Not all months had the same number of audits. The graph, however, displayed the total sum for all audits. Thus, it was not a fair comparison from month to month because some months had five audits, some had six, and in the future, some might have seven. The URCs and data analyst should come up with a way to control for this, such as doing an	

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		average per audit. Given the current set of data, doing so would indicate a more striking improvement than indicated by the current graph. In other words, the data showed an improvement (i.e., reduction) in the number of errors, especially over the last quarter, through December 2013. o Further, some months included a change in scoring, such as an increase in "thinning" errors in October 2013. The URCs should include an narrative sentence or two to explain any aberrations in data that are due to a change in the measurement system because looking solely at the graph would indicate that performance had worsened, when it hadn't. • Number of corrections made each month o A better way to present these data might be to do a percentage, that is, the percentage of errors that were corrected by the end of the month (rather than a raw number because if the number of errors varies per month, so would the number of corrections). Given their current set of data, doing so would result in graphing these percentages across the six months: 65%, 63%, 80%, 64%, 71%, 84%. These percentages show a steady <u>increase</u> in the percentage corrected. The line in the current graphs does not portray this kind of improvement. • 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 June 2013 through November 2013. • Three bar graphs separated by unit: o Number of errors, separated by unit. o Number of corrections made, separated by unit. o Different types of errors, separated by unit. • Three bar graphs separated by record clerk: o Number of errors, separated by record clerk. o Number of corrections made, separated by record clerk. o Different types of errors, separated by record clerk. The monitoring team recommends that, once the V4 activities are more developed, data on performance for each of those six components also be graphed. It is important that data and graphs be reviewed and analyzed so that decisions can be made regarding actions to correct and/or improve performance. The LSSLC URCs demonstrated this. A good example was their analysis of the missing documents category of errors. They found that it included many types of errors, such as documents not being current, documents being incomplete, or documents being inaccurate, rather	

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		than actually being missing (i.e., absent). As a result, they created more categories that will let them focus better upon areas needing improvement. Another example was their finding that many of the errors were related to thinning of the active record. As a result, they focused upon this. Ultimately, the graphs should be included in the facility's QA program, QA report, and QAQI Council presentations. Although section V was occasionally on the agenda, data and graphs were not being presented.	
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.	There are 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 continued to improve upon the way they addressed 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 (50%). 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> LSSLC reported that they addressed and documented this during the conduct of the monthly quality assurance audits (section V3) and that records were accessible to clinicians and staff. Indeed, in the audit tool, the record clerk rated whether each of the three components of the unified record was accessible to staff. The audit tool, however, did not indicate the criterion that the record clerk was to use, therefore, the monitoring team was unable to determine the validity of these ratings. Furthermore, the monitoring team looked at the active record check-out binders in a number of the homes and found that 60% of the missing volumes were not checked out correctly, that is, there was no signature or note regarding who took the volume and where it might be (Individual #174 volume 2; Individual #497 volume 3, Individual #185 volumes 2 and 3). The monitoring team's observations were vastly different than the facility's self-assessment, which found 32 of 32 active records to be maintained and available on the home. The 32 active records in that sample were the 32 records that received the monthly audit. Perhaps the facility should assess a wider sample of the status of the availability of the active records.	Noncompliance

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		Further, during the medication variance committee meeting, members of the nursing staff talked about the "fight for charts," that is, their difficulty in having access to the active records. Given the above, this aspect of V4 was not in substantial compliance. The monitoring team also observed that: • Individual notebooks were generally accessible and available to direct support professionals. • 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 all (100%) of the individual notebooks in the sample • The active records were available to the habilitation clinicians (OT, PT, SLP, and the PNMT). This was important because many of the IPNs were handwritten and completed at the time of the contact. <u>2. Data are filed in the record timely and accurately</u> For this item (#2), the monitoring team looks to see if the documents in the active record are up to date. This differs from the item immediately below (#3) for which the monitoring team looks to see if current data sheets are being completed expediently and correctly (e.g., behavior data sheets, seizure logs, PNMP logs). LSSLC was assessing this during the monthly audits, that is, when the record clerks 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: • An inservice was again held (11/15/13) with record clerks to talk about ensuring documents were filed in a timely manner. • The process continued of having record clerks, in the late evening of the last day of each calendar month, work directly with the overnight staff to transfer documents to the active record and to get the individual notebook set up for the new month. • The monitoring team's review of a sample of active records, follow-up discussion with the URCs regarding what was found to be missing, and the URCs' own data graphs indicated that some items were not filed timely. However, overall, more than 90% of items were filed in a timely manner. The URCs might use their data to determine if items found missing or not current during the monthly audits	

#	Provision	Assessment of Status	Compliance
		were due to delays in filing by the record clerks or due to delays in the submission of the documents to the record clerks. • An ISP tracking sheet continued to be used to track that the ISP was received by the record clerk and filed in the active record. o The facility had begun gathering data on the submission of documents for the active records. A list provided by facility reported that 43 (34%) of the 126 ISPs developed between July 2013 and October 2013 were not filed within 30 days of the annual IDT meeting. Data should continue to be collected on this variable and intervention taken if not improved. • This component of V4 was in substantial compliance. <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. • A new behavioral health department form was being used to look at the up-to-the-minute record of behavioral data. This was good to see. No data were provided by the URCs. The monitoring team's own observations were that only 58% of the PBSP data were recorded in a timely manner, that is, during the monitoring team's direct observation of the data sheet. • Active treatment coordinators were reviewing SAPs for timeliness and accuracy. This was good to see. Although the procedure was occurring at least since July 2013 (based on the example given to the monitoring team), there were no summary data, actions for improvement, or feedback system for staff and managers. • Habilitation therapy and the URCs were not yet determining if data were documented and recorded in a timely manner on habilitation-related therapies. • Data for direct habilitation therapy was generally reported in treatment notes. Monthly reviews were consistently completed in a timely manner and typically contained a report of actual clinical data as it related to established objectives of intervention with appropriate analysis, though content and quality varied. • Medical and nursing departments and the URCs were not yet determining if data were documented and recorded in a timely manner on medical- and nursing-related therapies. • Annual medical assessments in the AR were unsigned. • Annual medical assessments had prolonged delays prior to transcription. • Medical dictations lacked the appropriate time date stamps. • QDRRS in records were unsigned (presumably not reviewed) by psychiatrists. • For a number of IPN entries, the time was illegible or had an omission for the	

#	Provision	Assessment of Status	Compliance
		time. • A number of entries were prefaced "late entry." • This component of V4 was not in substantial compliance. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> As noted in the previous report, clerks 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. This was done via two "column" items for each of the three components of the unified record: "provides information for routine decisions making," and in the fourth question about there being evidence that the record was used to make care treatment and training decisions. Specific criteria, however, really need be specified for this because the reader cannot determine how the record clerk made the determination (which was usually rated to be yes). In addition, findings should be summarized and reported for this item of V4. Further, a sample wider than only using the monthly audits might be useful to the URCs. In addition, the monitoring team observed that: • The documentation by the PCPs was illegible in most cases and inadequate for the complexity of the problems. There was insufficient information to assist in clinical decision-making. • There was no evidence that the PCPs used the info in the MOSES and DISCUS evaluations. • There was no evidence that psychiatrist were using information in the QDRRs. • There was clearly a review of the active record in the PNMT, OT/PT, and SLP assessments. • This component of V4 was not in substantial compliance. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> The 10 V4 interviews reviewed by the monitoring team (i.e., 10 attached to each of the 10 audits) were across a variety of staff groups. 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, the URCs created a spreadsheet to more easily look for trends, and they graphed some of the data. In addition, the monitoring team observed that: • During opportune times of medication rounds conducted by the monitoring team, questions were posed to both the RN and LVN staff as in what situations they refer to the individual's active record. Responses were, for the most part, correct.	

#	Provision	Assessment of Status	Compliance
		• Psychiatry clinic staff used other information with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES, DISCUS, nursing information, and other clinical 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: • The QIDP facilitator provided IDT members with a draft ISP and IHCP at the annual team meetings observed. Data from assessments were entered into these two forms, so that team members could reference current assessments when developing necessary supports. o Some necessary information/data needed to make informed decisions regarding risks ratings was not available at all three annual ISP meetings during the onsite review. • Pre-ISP meetings were observed for Individual #326 and Individual #502. The QIDP used information in the active record to update IDT members to help them determine which assessments were needed prior to the annual meeting and to review progress towards outcomes. • The active record was present at the ISP meeting for Individual #418. • The active record was present at the ISP meeting for Individual #551 and was referenced at different times during the meeting. o The RN Case Manager, when questioned by the IDT about the individual's seizure activity, used the active record to provide the most current information regarding pertinent information about the individual's seizures. • The active record was present at the PNMT meeting for Individual #368. • The active record was present and used at psychiatric clinics. • The active record, when making decisions about wound care, was not available at the time when wound care rounds were made. It should have been available in order to make assessments or comparisons with previous assessments and/or treatment plans. This should be addressed. • This component of V4 was in substantial compliance.	

#	Provision	Assessment of Status	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: • Ensure accessibility of records, including a process to address any problems, track outcomes. • Determine if data are being recorded in a timely manner. • Determine criteria for IPNs indicating use of the record to make decisions, track outcomes.	

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
ACB	Anti Cholinergic Burden
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ACS	Assessment of Current Status
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
ART	Administrative Review Team
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
CMD	Choking, Modified Barium Swallow Study, and Dysphagia Committee
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
COS	Change of Status
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
COS	Change of Status
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
DDI	Drug Drug Interaction
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
DPN	Dental Progress Note
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
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EBWR	Estimated Body Weight Range
EC	Enteric Coated
EC	Environmental Control
ECG	Electrocardiogram
ED	Emergency Department
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
GA	General Anesthesia
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
H&P	History and Physical
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HCV	Hepatitis C Virus
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
IPMP	Integrated Pest Management Plan
IPN	Integrated Progress Note
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
IRT	Incident Review Team
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology

ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
JNC	Joint National Committee
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
LTBI	Latent TB Infection
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
MCC	Medical Compliance Coordinator
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
MIT	Mealtime Improvement Team
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
MTC	Meal Time Coordinator
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 Instructions
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
PMR	Protective Mechanical Restraint
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
RPN	Risk Priority Number
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
SIT	Skin Integrity Team
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
TLSO	Thoracic Lumbar Sacral Orthotic
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
VP	Ventriculoperitoneal
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
VZV	Varicella Zoster Virus
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