United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

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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 ensured that the monitoring team received documents, and she assisted with scheduling.

Due to a variety of primarily medical and nursing related concerns identified during the January 2014 compliance review, the monitoring team conducted a mid-cycle onsite review in May 2014 that focused on 12 specific topics.

Overall, attention was paid to all 12 topics, but progress and improved outcome varied across the 12. Moreover, during this compliance review, the monitoring team identified other serious concerns, again, primarily regarding the provision of medical and nursing supports and services. These are listed below, after the 12 topics. Below are some brief comments regarding these areas, taken from the more detailed monitoring team's full report.

1. Preventive healthcare:
    - Preventive care data were being tracked by the medical department in an ongoing manner.
    - Improvement was seen in the completion of the Preventive Care Flow sheets and Quarterly Medical Assessments, and in the updating of the Active Problem Lists.
    - Compliance with breast cancer screenings increased and compliance with colorectal cancer screening remained high.
    - There were modest improvements in some elements of preventive care. Cancer screenings were increasing and the Zoster vaccination was being provided to individuals over the age of 60 years.
    - The facility was utilizing the services of an advanced practice registered nurse to complete pelvic exams and cervical cancer screenings. Preventive care data, however, were presented in a manner that resulted in factitiously increased compliance rates for cervical cancer because it appeared that not all women who were examined received a pap test.
    - The Preventive Care Flow sheets were found in 100% of the records reviewed. Most appeared to have been updated. The medical LVNs assigned to each PCP completed these documents, and signed and dated the documents at the time of updating
    - LSSLC staff reported that they now utilized the American Cancer Society guidelines for mammography, but written facility policy was not consistent with these ACS guidelines. Per the ACS: "Yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health." The USPTS recommends mammograms until the age of 74 years.

2. Annual medical assessments
    - Overall, there was little improvement in the quality of the AMAs. The majority of AMAs failed to link key elements and provide a robust medical plan for the active problems.
    - Consults, sick call visits, and diagnostics were listed without utilizing this information to synthesize a cogent plan of care for active medical problems.
    - Some AMAs failed to demonstrate the association between problems such as GERD, aspiration, and pneumonia.
    - Multiple assessments included labs that appeared to be copied and pasted from the actual lab reports. Entire consults were also cut and pasted into some evaluations. This practice provided little value and ultimately diminished the usefulness of the assessments.
    - The plans of care in many of the AMAs were not adequate. Providers continued to write plans, such as "follow-up with GI" or "continue G-tube feeds."

- Most AMAs were disjointed and failed to provide a snapshot of the individual's health status, however, one provider continued to generate assessments that were thorough and provided good information about the health status of the individuals.
- Compliance with timelines was 96%.

3. Osteoporosis care and management
    - 130 individuals were diagnosed with osteoporosis; 120 of 130 (92%) individuals received pharmacologic therapy; and 110 of 130 (85%) of individuals had DEXA scans.
    - The facility considered a DEXA scan current if done within the past three years. The International Society for Clinical Densitometry, the National Osteoporosis Foundation, and the American Association of Clinical Endocrinologists all recommend BMDs to be done within one to two years of starting or changing therapy. Thus, the three-year guideline was not consistent with the recommendations of the major professional organizations.
    - LSSLC did not provide comprehensive data for osteoporosis management. Data were limited to the timeliness of obtaining bone mineral density studies. The facility presented a DUE on osteoporosis in April 2014, but it simply indicated the number of individuals receiving the various osteoporosis drugs alone and in combination with PPIs and antacids. The report did not look at the overall management of osteoporosis, such as the appropriateness of medical management.
    - The facility implemented chart audits for management of osteoporosis in April 2014. The tools covered many of the performance measures proposed by several major professional organizations. Audits for the three months resulted in the review of 13 individuals. Given the number of individuals with the diagnosis, a more efficient means of obtaining aggregate data related to osteoporosis management is needed.

4. Pneumonia care and management
    - The facility still had a great deal of work to do in order to improve the pneumonia review process as well as the overall management of pneumonia, specifically management of recurrent aspiration.
        - This should be considered a priority for staff due to of the morbidity and mortality associated with aspiration.
        - Documents reviewed showed that in recent months, at least two individuals experienced respiratory and/or cardiac arrest and required intubation and mechanical ventilation because of aspiration (Individual #202 and Individual #357).
        - Other individuals were developing chronic and irreversible pulmonary changes due to recurrent aspiration.

- Several individuals had recurrent pneumonia and there was little evidence that proper consideration was given to the interventions that needed to be implemented to minimize risk and recurrence. The medical staff rarely documented what, if anything, would be done to minimize risk.
    - During fiscal year 2013, 17 individuals had more than two cases of pneumonia for a total of 40 events.
    - For fiscal year 2014, 15 individuals had multiple pneumonia episodes for a total of 33 events as of 5/31/14.
    - Forty-five cases of pneumonia were reported in FY2012, 88 in FY2013, and 66 in FY2014.
    - The hospital reports and daily clinical meetings minutes documented many individuals with a diagnosis of pneumonia.
    - Numerous cases of recurrent pneumonia are presented in case examples in sections L, M, and O below in this report below.
- Documentation in the records did not support that the IDT or PCP had considered the next course of action or discussed the etiology of the aspiration - seizure, aspiration of gastric contents, or aspiration of upper airway secretions. Continued management requires a thoughtful discussion of many factors in order to take the next most appropriate actions.
- Since the last compliance review, the facility formed a Pneumonia Review Committee. The group needed prompting from the monitoring team to move forward with a discussion on the factors contributing to aspiration and how those could be minimized.
    - The pneumonia review committee lacked pharmacy input. Knowledge of the medication profiles of the individual is important in the management of pneumonia.
    - The CNE implemented a Pneumonia Event Root Cause Analysis Process (PERCA) in May 2014.

5. Infection control practices
    - The facility developed and implemented hand hygiene education, audits, and posting of hygiene reminders.
    - Aspects of Medication Administration were not consistent with established standards of infection control practices associated with administering medications. General infection control practices were not adhered to and required prompts, regarding use of gloves, exchange of gloves, hand hygiene, and cleaning of stethoscope between individuals.
    - The facility scheduled and held Infection Control meetings in accordance with their policy. Although there were reports of infections, the discussion did not examine any increases or decreases in the number of infections, what was working, and what was not working regarding their infection control systems to effectively reduce the transmission of infections.
    - Staff were not following acceptable standards of infection control and applicable isolation procedures.
    - There was no PNMT representation at infection control meetings.

- Individual #275
    - There was a failure to follow established infection control practices to prevent transmission.
    - During observations of the suction catheter, the facility was not following infection control standards of care, on two consecutive days, even though, the monitoring team had reminded the nurses of the infection control issue.
    - The facility failed to protect the individual airway from containments. The monitoring team observed a fan, which was dirty, blowing directly on the individual's face, neck, and tracheostomy area.
- Individual #361 was isolated for C-diff, in the Infirmary, in a room set up to provide isolation.
    - Signage was located on the door. It stated the type of contact isolation and instructions, but was not written in language that would be easily understood by all staff.
    - An isolation cart was present and contained sufficient gowns, gloves, and masks.
    - There were adequate containers for disposing of waste and soiled linen.
    - The facility had a record for documenting terminal cleaning of the isolation room and area.
    - During rounds on two consecutive days, the isolation room exit door was open. Because C-diff is a spore-forming organism and environmental contamination can occur, it is important to ensure exit doors to the room are closed.

6. Skin integrity practices
    - The facility had taken a number of steps to address the management of pressure ulcers. A wound clinic was started with a certified wound nurse. The skin integrity policy was revised and pressure ulcers were discussed weekly in the daily medical meeting.
    - The facility developed and implemented education in Skin Care and Wound Prevention for nurses.
    - There were improvements in wound clinic, including assessments performed by the certified wound specialist, proper equipment and lighting, privacy, and presence of records.
    - Even so, the findings related to the incidence and prevalence of pressure ulcers was troubling because a number of individuals had pressure ulcers discovered at Stage III. During the week of the compliance review, Individual #556 was reported to have a new Stage IV pressure ulcer. The prevalence of pressure ulcers is an important quality indicator.
    - Discovery of Stage III and Stage IV pressure ulcers is a serious incident. Professional organizations, such as The National Pressure Ulcer Advisory Panel recommend that ulcers discovered at stage III and stage IV result in a utilization of processes, such as Root Cause Analysis to (1) determine and gain insight into the development of pressure ulcers through a review of timelines of the event, (2) discover gaps in care, (3) determine compliance with facility protocols, and (4) review the facility's skin management protocols.

- While the facility had policies related to pressure ulcers, the medical department did not have a formal policy or guidelines to provide direction to the medical staff on pressure ulcer management. The medical staff should be intimately involved in the management of care. Equally important is the physician's role in identifying individuals at risk and ensuring that appropriate measures are implemented.
- Identification and monitoring did not occur as per the generally accepted professional standard of care.
    - Nursing services and supports were not consistently monitored, and specific progress or regression was not documented, including when the individual had a change in skin integrity. For example, Individual #556 was not consistently monitored for his risk of skin integrity, even though the IDT had met and determined to raise his risk from low to medium.
    - Individual #556's decubitus was diagnosed as a Stage IV. The facility should immediately review what actions, or lack of actions, led to the individual acquiring a significant change of status.
    - Four individuals were identified as meeting criteria for PNMT referral related to skin integrity (Individual #467, Individual #316, Individual #46, Individual #586, and Individual #556). None had been referred, nor had the team initiated a self-referral. Some were recently staged as III and IV.
    - Individual #357's Nursing IPN, associated with the required Post Infirmary Assessment, did not consistently address whether or not the skin integrity issues were improving or regressing.
- There was no PNMT representation at skin integrity meetings.
- All of the QA department corrective action plan steps to address skin integrity/decubitus were completed, but individuals continued to have occurrences of decubitus.
- The system recently developed for PNM monitoring that used the threshold database to identify individuals who experienced health/risk concerns, but have not yet reached criteria for PNMT referral appeared to be a promising approach. It was of concern that the monitoring conducted had not sufficiently addressed the occurrences of major skin wounds in a number of individuals.

7. G-tube placement and decision making
    - 83 individuals received enteral nutrition at LSSLC, that is, 25% of the total census.
    - 0 of a sample of 4 individuals with APENs had an appropriate evaluation to determine the medical necessity of the tube since the previous review. There was no determination if the feeding schedule was the least restrictive or if there were potential modifications needed in preparation of transition to oral intake.
    - There were five individuals listed who had received enteral tube placements since the previous review (Individual #422, Individual #238, Individual #185, Individual #447, or Individual #67).
        - 0 of 5 (0%) of individuals who received a feeding tube since the last review had been referred to the PNMT prior to the placement of the tube.

    - 0 of 5 (0%) individuals who received a feeding tube placement since the last review had been referred to the PNMT after the tube placement. There was no evidence of review by the PNMT. None of these appeared planned, but it was not clear if they were placed on an emergency basis, precluding review by the team.
- A new special ISPA form was to be completed prior to new G-tube placements. The new form included a number of prompts for discussion by the IDT. It was not yet implemented.
- Review of the medical necessity of enteral nutrition was initiated for individuals with existing tubes as well as a protocol for the review of each case prior to new tube placement. The facility should carefully analyze the risk/benefit of every tube placement and make a determination on clearly identified clinical indicators. Following tube placement, there should be clear consideration for movement along the continuum of the least restrictive methods of intake. While not all individuals would be expected to return to oral intake, careful consideration of least restrictive supports is essential.
- The use of tubes has some disadvantages, however, they are indicated in the face of recurrent aspiration of gastric contents. The use of the jejunal tubes should not be dismissed solely based on the facility's history. Rather, the facility should determine if staff training played a role in the failures associated with use of the jejunal and gastric-jejunal tubes.

8. Falling
    - A corrective action plan was developed to address the high incidence of falls at the facility.
        - Fall prevention training was provided to Oak Hill and Lone Pine residential staff.
        - It was difficult to determine what specific actions had been implemented, how they were being monitored, and what data were used to determine the efficacy of the plan.
    - There were problems with IDT and facility review and action
        - Individual #344's recommended vision assessment was not completed prior to her ISP meeting. The QIDP reported that she had five falls over the past year. Supports were developed without consideration of how her vision might be contributing to her high number of falls.
        - Individual #238's IDT met in May 2014 to review three additional falls. The team rated him as high risk for falls, but failed to update his IRRF or IHCP.
        - Individual #410 was rated as low risk for falls even though he had three falls the previous year with one resulting in a serious injury.
        - The incident management department had identified a trend of falls for Individual #90. A review of her file showed that the IDT failed to consistently review her fall data and follow-up on recommendations made to address her falls. Her IDT submitted a referral to the PNMT on 6/18/14. At the time of this monitoring visit (a month later), the PNMT had still not addressed the referral.

- Lists related to the incidence of PNM-related concerns were reviewed to determine if individuals who met the criteria above were appropriately referred to the PNMT. Related to falls, there were at least 15 individuals who had met criteria for three or more falls in three months. Only three had been referred to the PNMT (Individual #33, Individual #368, and Individual #90).

9. Helmet usage
    - Since the last review, the facility conducted an interdisciplinary review of helmet use for 22 individuals to determine the purpose of use. Eighteen of those were being used for protection from injury during seizures and falls.
    - Each unit was regularly reviewing the use of helmets and developing strategies to minimize use when appropriate.
    - A new ISPA form was developed with prompts for discussion to review the use of restrictive devices. The monitoring team encourages the facility to continue to review all restrictive devices to ensure that they are the least restrictive treatment method, safely used, carefully reviewed and monitored by the IDT, applied the minimal amount of time deemed necessary, and faded when no longer appropriate.
    - The facility reported that 14 individuals at the facility wore protective mechanical restraints (PMRs). This included four of the helmets, mittens, and wristlets. The facility had begun reviewing the use of helmets in unit meetings.
    - Behavioral Health Services Department developed PMRPs for three individuals with PMRs used for crisis intervention to include a schedule of release, monitoring guidelines, and strategies for decreasing the use of the restraint. Those plans were not submitted for review.

10. Death and mortality reviews
    - The monitoring team is concerned that significant medical issues were not surfaced through the mortality review process indicating the continued need for a comprehensive and objective review of the medical care to be completed with each death. This review 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.
    - Facility staff reported that a mortality review was done by state office. However, the findings were not provided to the monitoring team.
    - A review of the active records indicated that there were several issues related to the provision of health care that should be addressed, including problems related to bowel management, physician notification, and physician response to issues.

- Additionally, the concern related to Topamax use and the risk of kidney stones was a significant problem for one individual who appeared to become septic after having a procedure for an obstructing renal stone. These issues did not appear to be captured in the mortality-related reviews that were completed.
- The Mortality CAP tracking, February 2014 through April 2014, contained 15 recommendations, for which six were recommendations for nursing. All of the six nursing recommendations were documented as completed. Even so, the nursing recommendations did not include action steps for how the facility planned to evaluate the effectiveness of the implemented recommendations.

11. Medical quality program
    - Progress was seen with the development of the medical quality program. The quality program requires revision and continued work, but the facility made good progress by defining indicators, developing tools, and conducting audits. With implementation of the audits, the medical department now had several key components of a medical quality program.
    - LSSLC should continue to identify metrics (process, outcome, and structural) to be measured.
    - A specific medical quality committee is needed. As a formal committee, the medical director should serve as the chairperson and minutes should be taken and forwarded to the facility director and QA department.
    - Quality programs require a number of structures, including a Committee, calendar, clinical practice guidelines, policies and procedures, peer review process, chart audits, tracking systems, and data sources. LSSLC had a number of these processes in place and this was a good start.
    - Even so, it appeared that a number of serious issues were not being detected with these systems. This may be a function of the reviewers or the tools that are being utilized. It would be beneficial for the facility to review all of the audit tools to ensure that the most relevant metrics are being assessed.
    - The monitoring team has already discussed some of the discrepancies relative to clinical care standards. Those discrepancies must be addressed so that valid and reliable audit tools can be developed. The tools need to measure the specific concept that is intended to be measured.

12. Medical leadership
    - A new medical director was appointed in June 2014. He had worked at the facility for a number of years.
    - The role of medical director was broad and he was learning all that it entailed.
    - Facility staff responded well to his direction and expressed appreciation for the work that he was doing.

Five additional important topics of concern were identified during this compliance review by the monitoring team. Brief comments are provided here; more detail is in the report below. The monitoring team suggests that the facility director and state office work with facility management to address these concerns, too.

13. Renal/kidney monitoring

- Nephrolithiasis appeared to be a source of morbidity. The actual prevalence was not known, but an unusual number of individuals were noted to have kidney stones. Several of these individuals were treated with topiramate. It was disconcerting to find that this association had not been detected, particularly because the use of topiramate and the propensity to cause metabolic acidosis was highlighted in section N of the last monitoring report.
- The facility had not detected a trend in kidney stones nor made any association between the use of Topamax and kidney stones. Given the complexity of the medication regimens and the risk of metabolic acidosis, the facility must address this concern.
- The medical staff must be aware of the side effects of frequently used high-risk medications and implement appropriate strategies to mitigate risk and monitor for adverse outcomes. Moreover, the medical staff should be cognizant of the increased risk of adverse outcomes due to the multiple medications prescribed to the individuals.
- This issue was discussed in detail in section N2 of the monitoring report for the January 2014 compliance review and is discussed in detail in sections L1 and L2 below.

14. Bowel management

- Bowel management continued to present challenges. The facility did not have aggregate data on acute interventions, such as enema and suppository use, but during the daily morning meetings, the monitoring team heard reports of numerous individuals who required suppositories and enemas for management of constipation.
- There were many hospital admissions related to ileus and several individuals experienced poor outcomes.
- As noted in the last report, many individuals received multiple medications, in some instances four or five, for the management of constipation.
- During the daily medical meeting, the monitoring team heard reports of numerous individuals requiring enemas due to constipation. The facility director reported that she had also noticed an increase in use and an association with seizures and with vomiting. Yet, the facility had not done any further exploration of this observation. This was disconcerting because reports indicated that several individuals who had aspiration were known to have emesis and associated fecal impactions and there were numerous hospitalizations associated with the diagnosis of ileus.

- Documents reviewed by the monitoring team revealed poor outcomes associated with constipation for many individuals, such as Individual #101, Individual #527, Individual #517, Individual #357, and Individual #109. Details are in the case reviews in sections L and M below.

15. Hospital admissions from the emergency room
    - Data provided to the monitoring team documented that from September 2013 to June 2014, LSSLC had the highest number of emergency room visits that resulted in hospital admission of the 13 SSLCs. Further, LSSLC had the second highest number of total hospital admissions. High rates of hospitalization may signal quality problems and require further analysis

16. Nurse notification of physicians
    - There was an abundance of evidence that physician notification of illness was a major concern at LSSLC. The majority of the records reviewed provided documentary evidence that physicians were not being notified of acute medical problems.
    - Facility management was aware of this because the daily meeting minutes often included examples of communication that should have occurred with the physicians, but did not.
    - Individual #502: A warming blanket was applied to the individual, but there was no documentation of physician notification of a change in status. A series of late entry notes documented no improvement in status, but again there was no notification of the on-call physician. There was a series of assessments that documented the deterioration in this individual's status, but there was no notification of the PCP for more than 12 hours.
    - Individual #517: The record included multiple IPN entries, but none documented physician notification.
    - Individual #556: The record did not contain notification to the physician for the incident that required nursing intervention
    - Individual #218: The individual was found to have a residual over 100 cc, which required notification to the physician.

17. Individual #410
    - This individual presented a variety of behavioral, psychiatric, and medical challenges that were, in many ways, beyond the capability of the facility. The IDT and facility were aware that the facility was not the appropriate place for him because they did not have the behavioral, psychiatric, medical, and safety supports that he needed. The facility and IDT have been unable to find any other more appropriate placement for him. The monitoring team does not know if they have accessed assistance from state office. If not, the facility should do so immediately.

- Individual #410 had 15 chemical and 50 physical crisis restraints in the four-month period from 1/1/14 to 5/15/14. Eleven of these lasted more than two hours. He exhibited severe SIB and a new safety helmet was recently developed.
- He has had numerous trips to the emergency room and several serious injuries. He was spending more and more time restrained and has had numerous restraint related-injuries.
- He has a variety of medical concerns, too, such as cardiac problems, further compounding medication and treatment challenges.

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 180 restraints used for crisis intervention involving 18 individuals between 1/1/14 and 5/31/14. The number of restraint incidents had increased since the last onsite review. However, Individual #410 accounted for 108 of the 180 (60%) restraints (i.e., the number of restraints had increased for this one individual, but the use restraints had decreased for other individuals at the facility).
- There were 55 instances of pretreatment sedation for routine dental/medical appointments for 42 individuals from 1/1/14 through 5/31/14. This appeared to be a reduction from the last six months, however, data collection was not consistent to allow for comparison.
- The facility reported that 14 individuals at the facility wore protective mechanical restraints (PMRs). This included helmets, mittens, and wristlets. The facility had begun reviewing the use of helmets in unit meetings. It still was not evident that restraint plans were being developed consistently to instruct staff in when to apply, remove, and monitor the restraint in compliance with state policies.
- Since the last review, the facility had conducted an interdisciplinary review of helmet use for 22 individuals to determine the purpose of use. Eighteen of those were being used for protection from injury during seizures and falls. Each unit was regularly reviewing the use of helmets and developing strategies to minimize use when appropriate. A new ISPA form was developed with prompts for discussion to review the use of restrictive devices.

Abuse, Neglect, and Incident Management

- Of 64 allegations, there were eight confirmed cases of physical abuse, one confirmed case of verbal/emotional abuse, four confirmed cases of neglect, and no confirmed case of exploitation between 2/1/14 and 7/11/14. The facility reported that 22 other serious incidents were investigated by the facility during this period.
- There were 1268 injuries reported between 12/1/13 and 5/31/14 that included 15 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 had been a decrease in both the total number of injuries and the number of serious injuries reported the previous six months.
- 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.
- 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. Further, the facility should implement appropriate follow-up to findings (i.e., complete a CIR for injuries not reported).
    - D.3.i: The facility was not documenting implementation of recommendations and 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 not yet following up on action plans to address trends to determine if desired outcomes were achieved. IDTs were still not adequately addressing trends of injuries and incidents.

Quality Assurance

- The QA program at LSSLC made more progress than ever before. Substantial compliance was maintained for section E3 and obtained for section E4. The previous QA director left the facility in May 2014. The SAC was appointed to be the new QA director.
- The QA director and the department heads developed a list called "Final Key Indicators" for each of the 20 sections of the Settlement Agreement. These lists appeared to be comprehensive. At the same time, the QA department maintained a data list inventory document. It did not line up with the content of the final key indicator list. Thus, the facility had two disparate lists of data. The new QA director needs to create a single data list inventory.
- The LSSLC QA report was initiated in May 2014. Of the 20 sections of the Settlement Agreement, 18 (90%) appeared in a QA report at least once each quarter in the last six months. Because QA reports were only recently created, the monitoring team included the data and slides presented at QAQI Council prior to the initiation of the QA reports in May 2014.

- There were 19 open CAPs. They were related to 8 Settlement Agreement provisions. Of the 8 CAPs reviewed by the monitoring team, 8 (100%) appeared to appropriately address the specific problem for which they were created. 6 of the 8 (75%) had measurable criteria (i.e., the newer CAPs). 8 of the 8 (100%) CAPs looked at assessing outcomes to ensure that the problem originally identified was remedied or reduced. The QA PCM kept a detailed spreadsheet that summarized the status of all CAPs and their action steps. She reported to QAQI Council on the status of the CAPs.

Integrated Protections, Services, Treatment, and Support

- During the last review, the QIDP Coordinator indicated that the facility had chosen to focus on improving attendance by team members identified as "required" at the annual ISP meeting and the submission of assessments identified as necessary prior to the annual meeting. Improvements were noted in both areas. These were good first step to ensuring that comprehensive ISPs were developed for each individual annually.
- Little progress was noted, however, with the development, monitoring, and revision of ISPs. The facility acknowledged that little progress had been made since the last review. This was in part attributed to turnover in the QIDP department, including resignation of the QIDP coordinator.
- Two annual ISP meetings were observed. Teams were not using preferences to build on new training opportunities for individuals. Observation at both day and residential programs confirmed that individuals were engaged in minimal meaningful activity throughout most of the day.
- The facility did not yet have an adequate process in place for monitoring supports and services. Thus, it was not evident that supports were consistently implemented and/or revised when needed.

Integrated Clinical Services

- The facility made some progress in this area. The Quality Services Review process, which was developed to measure integration of services, was finalized. Eight audits were conducted and feedback was provided to the teams.
- A number of processes showed improvement with regards to integration of services, including the suction toothbrushing program, skin management, dental desensitization, and the oversight of psychotropic polypharmacy. The daily medical meetings were expanded to include more discussion of clinical issues.
- There was evidence that integration was occurring. However, there were several areas that needed substantial improvement. Physician participation in annual ISPs and the Medication Variance Committee meetings remained poor.
- There was improvement in the use of IPN template for consultation documentation. The content of many notes, however, was problematic. The notes were increasingly becoming a copy of the consult text. Moreover, the providers were not referring the recommendations to the team even when it was clearly beneficial to do so.

Minimum Common Elements of Clinical Care

- Progress was made in provision H1. The facility had addressed the timeliness of annual and quarterly assessments. Clinical disciplines had also developed tools to address the quality of annual assessments. Most disciplines had also developed tools to determine the quality of quarterly assessments. There were no systems in place to track interval/unscheduled assessments by the clinical disciplines.
- Overall, for psychiatry services, the diagnostic formulation documentation was appropriate. The medical providers generally utilized ICD nomenclature and the diagnoses were consistent with the signs and symptoms of illness.
- The facility had a local policy for addressing this provision. It covered 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

- Since the last review, the facility implemented a number of procedures to address risks including a root cause analysis protocol implemented following a diagnosis of pneumonia. Corrective action plans were developed to address the high incidence of falls and skin breakdown at the facility. The CNE and QA staff had provided additional training on change of status expectations related to the risk threshold data and risk database.
- The monitoring team observed the risk identification process at two ISP meetings. Each discipline presented relevant information included in the IRRF during the risk determination process. Although a lot of information was read from the IRRF, little time was spent engaged in discussion that might have aided the IDT in developing integrated supports. Both IDTs reviewed supports that were already in place and agreed to continue most supports without discussing how those supports might be modified to result in better outcomes for the individual. T
- Provision I3 requires evidence that plans were implemented in a timely manner once risks were identified. The facility reported that due to the turnover in the QIDP department, ISPs were often not filed and available for implementation within 30 days of development. The QIDP Coordinator indicated that this was a focus area for the QIDP department.

Psychiatric Care and Services

- Psychiatry services at LSSLC made progress towards substantial compliance. The facility was found to be in substantial compliance with 10 of the 15 items in section J. Over half of the individuals residing at the facility received psychopharmacologic intervention (177 of 328, 53%).
- The facility made the transition from verbal/dictated documentation to electronic documentation utilizing a prepared shell. While the initial transition to electronic documentation was laborious, it will result in a time saving for the providers as it cuts down on redundant documentation.

- It was noted that, even with a reduction in FTE providers, psychiatry staff had managed to attend ISP meetings and other committee meetings. It was noted that psychiatry clinic staff were doing an excellent job scheduling and utilizing current resources to their full capacity.
- During this monitoring period, the facility achieved substantial compliance in J11. This was due to ongoing efforts by the facility staff to review polypharmacy regimens inclusive of those regimens meeting criteria for "combination polypharmacy." The facility had made strides with regard to the reduction of polypharmacy.

Psychological Care and Services

- Provision K9 was found to be in substantial compliance for the first time. The facility also maintained substantial compliance on the six items (K2, K3, K5, K6, K7, and K11) that were in substantial compliance prior to this review.
- Other improvements included continued development of behavioral systems to ensure that PBSP data are recorded in a timely fashion, are reliable, and PBSPs are implemented as written. There was development of a database to measure data timeliness, inter-observer agreement (IOA), and treatment integrity level and frequency. Staff showed consistent demonstration in the progress notes that some activity (e.g., retraining of staff, modification of PBSP) had occurred when an individual is not making anticipated progress
- The areas that the monitoring team suggests that LSSLC work on for the next onsite review are to demonstrate that established minimum frequencies and levels of data collection reliability, IOA, and treatment integrity are achieved; and to ensure that counseling services consistently contain documentation of progress on treatment goals and contain all of the required elements.

Medical Care

- The medical department of LSSLC continued to face many challenges. There was a series of staffing changes with the retirement of the lead physician and one long-term staff physician. A new medical director was appointed in June 2014. He had worked at the facility for a number of years.
- The facility was utilizing the services of an advanced practice registered nurse to complete pelvic exams and cervical cancer screenings. Preventive care data were being tracked by the medical department in an ongoing manner. This was effective in increasing the number of individuals who received preventive care services, such as cancer screenings. Compliance with breast cancer screenings increased and compliance with colorectal cancer screening remained high.
- The positive findings of this review were, to some extent, negated by a host of problems identified by the monitoring team. Several workgroups were created to address issues, such as pressure ulcers and pneumonia management. The impact of those efforts had yet to be realized because individuals continued to experience poor outcomes, such as bowel obstruction, ileus, recurrent pneumonia and stage III and stage IV pressure ulcers.

- Nephrolithiasis appeared to be a source of morbidity. The actual prevalence was not known, but an unusual number of individuals were noted to have kidney stones. Several of these individuals were treated with topiramate. It was disconcerting to find that this association had not been detected.
- There was an abundance of evidence that physician notification of illness was a major concern at LSSLC. Based on IPN documentation, it appeared that the physicians often did not respond to acute issues. However, physician orders frequently indicated that treatments and care were being provided.
- The facility conducted internal and external reviews as required, and implemented corrective actions. Progress was seen with the development of the medical quality program. The quality program requires revision and continued work, but the facility made good progress by defining indicators, developing tools, and conducting audits.
- Finally, data provided to the monitoring team documented that for the period of September 2013 to June 2014, LSSLC had the highest number of ER visits with admission of the 13 SSLCs and LSSLC had the second highest number of total hospital admissions. High rates of hospitalization may signal quality problems and require further analysis.

Nursing Care

- Nursing assessments and implementation of protocols, to varying degrees, did not consistently and sufficiently address the health status of the individuals. Records were problematic for incidents where there should have been physician notification.
- 12 of 24 (50%) nursing assessments contained the required components of the assessments. Examples of missing documents were physical assessments.
- The nurse's need more time, experience, and training with the problematic aspects of the nursing summaries.
- Nursing, DSP, and staff are re-educated about the signs/symptoms of constipation, the importance of being knowledgeable about the individual's bowel habits, the use of laxative, prn enemas, and health conditions that can occur when constipation is not appropriately managed.
- Systems need to be put in place to assure there are integrated systems for monitoring and assessing individuals who have potential risk for skin integrity issues.
- There needs to be improvement in staff and individual focus on risk of infections and practices to decrease risk, and systems to facilitate recognition of infections increases, clusters, and outbreaks.
- Aspects of Medication Administration were not found to be consistent with the facility's own audits, such as related to general accepted standards for administration/storage/security of medication, and following established standard of infection control practices associated with administering medications.
- 11 of 12 (91%) medication passes required prompts related to one or more of the essential items required on the facility's medication pass observation form, and other generally accepted professional standards of care.

Pharmacy Services and Safe Medication Practices

- There was very little progress noted in the provision of pharmacy services. In fact, regression was seen in a number of areas. A new clinical pharmacist began working at the facility on 5/6/14.
- There was documentation of communication between the prescribers and pharmacists, but it was minimal given the facility's census. There was a continued need to develop a process for managing drug interactions.
- Completion of QDRRs improved in terms of timeliness, but the content needed significant improvement. The QDRRs failed to adequately address many clinical issues, such as diabetes mellitus, hypertension, and the monitoring for endocrine risks, such as metabolic syndrome.
- Electronic completion of the MOSES and DISCUS evaluations did not appear to improve the process. In fact, it seemed to serve as a barrier to proper completion of the evaluations.
- The facility reported only four ADRs since the last compliance review even though examples of ADRs were seen in the records, consults, and other documents. Only one DUE was completed since the last compliance review. Quarterly DUEs were required.
- The facility continued to report medication variances. A number of process changes were implemented in order to address medication variances. A major concern with the medication variance system was the continued lack of physician participation.
- The pharmacy department appeared to be impacted by poor organization. The monitoring team requested a copy of all policies and procedures prior to the compliance review. The document submission provided no information. Moreover, pharmacy policies were not being reviewed and updated. That lack of effective management was impacting many aspects of pharmacy services.

Physical and Nutritional Management

- There was a fully appointed PNMT. There were significant concerns about the timeliness of the PNMT assessments and the timely response to referrals through the initiation of assessments or consultations.
- The mealtime observations highlighted improvements in the dining areas. There were very few implementation errors, though logistics and environmental issues continue to need refinement. In each area, a Mealtime Coordinator was present, but in two cases, they did not recognize concerns with implementation prior to it being brought to their attention.
- In general, individuals were positioned correctly, but there were significant concerns for skin integrity that suggests that there is still much work to be done in this area across the 24-hour day.
- Review of the medical necessity of enteral nutrition was initiated for individuals with existing tubes as well as a protocol for the review of each case prior to new tube placement. While it was noted that there were significantly fewer tubes placed, it could not be determined if this was a function of this new process. The point, however, is to not

summarily dismiss the need for a tube for the sake of lowering the numbers, but to carefully analyze the risk/benefit of tube placement and make a determination on clearly identified clinical indicators.

- The system recently developed for PNM monitoring that used the threshold database to identify individuals who experienced health or other risk concerns, but have not yet reached criteria for PNMT referral appeared to be a promising approach. It was of concern that the monitoring conducted had not sufficiently addressed the occurrences of major skin wounds in a number of individuals.

Physical and Occupational Therapy

- OT/PT assessments continued to improve. The essential elements section should be carefully reviewed so that content of some of the elements can be further refined.
- Further integration of OT/PT-related supports and services must be better integrated into the ISP.
- The monitoring team observed day program areas in which clear efforts to enhance the quality of those programs were evident. For example, a COTA was specifically assigned to the day program for that purpose. In addition, a Ladies Luncheon was established. It was clearly a success with the women who participated, and resulted in some very real changes in their level of participation and engagement. It was planned to expand this opportunity to others as well.
- Based on the monitoring team's direct observation of over 50 individuals, over 90% of positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition.

Dental Services

- The dental clinic continued to make progress under the direction of the dental director. The staff was a dedicated group of individuals who understood their roles in the delivery of dental services.
- Overall, the records reviewed indicated that most individuals were receiving timely treatment with most having frequent assessments and treatment.
- A number of new initiatives were in the process of being implemented to improve oral health. A periodontal program was developed to address individuals with moderate to severe periodontitis. The suction toothbrushing program was expanded to treat more at-risk individuals. The hygienists and the dentists conducted random observations in the homes. The completion of radiographs increased and the clinic had acquired portable equipment that allowed even more individuals to have the necessary radiographs.
- Individuals were followed in clinic based on their overall oral health. Individuals with poor oral hygiene and those with moderate or severe periodontitis were seen every three months. The percentage of individuals with good hygiene increased while the percentage of individuals with poor hygiene decreased by half.
- The dental clinic collaborated with behavioral health services to address barriers to dental treatment. The clinic notified the behavioral health services department with individuals refused treatment or when individuals had poor oral hygiene believed to be associated with behavior.

Communication

- There was an exceptional team of speech pathologists at LSSLC. The continued delay in completion of communication assessments, and in a timely manner relative to the ISP must be corrected.
- There were a tremendous number of communication systems in place, though integration of communication supports were not consistently integrated into the ISPs.
- Consistency of documentation of direct supports and review of indirect supports was needed.
- Compliance monitoring focused primarily on the equipment, rather than also the implementation of supports. Effectiveness monitoring should reflect a review of all communication supports at least on a quarterly basis.

Habilitation, Training, Education, and Skill Acquisition Programs

- Improvements included a re-organization resulting in the staff responsible for writing skill acquisition plans (SAPs) being moved to the behavioral health services department. There was an overall improvement in the quality of SAPs, and the SAP integrity tool. There was also the establishment of a data system to track the implementation of SAPs in the community and engagement goals were determined for each day and home site.
- Areas of focus for the facility should include ensuring that SAP training instructions following an incorrect response are clear and tailored to individual needs, and prompt levels are included in all SAPs. All SAPs should focus on learning new skills and the number of communication SAPs for individuals with communication needs should be expanded. SAP data should be consistently graphed and used to make data based decisions concerning their continuation, discontinuation, or modification. Now that some goals have been set (e.g., engagement, community training), ensure that these goals are met.

Most Integrated Setting Practices

- The LSSLC admissions and placement department continued to make progress in most areas of section T. The number of individuals placed was at an annual rate of about 7%, a slight increase since the last review. 17 individuals were on the active referral list. 7 of the 17 individuals were referred for more than 180 days. Even so, reasonable activity and actions had occurred related to the transition and placement almost every individual.
- There were systemic issues delaying referrals. 45% of the 71 individuals whose ISPs were reviewed by the APC were not referred solely due to preference of the LAR. Obstacles to transition included the absence of providers who could meet the physical and accessibility needs of individuals, providers failing to return phone calls or emails from the transition specialists, and funding availability was cited as a barrier for three individuals.
- Independent recommendations from each of the professionals on the team were not presented and discussed during ISP meetings.

- CLDPs did not clearly identify a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition, such as including sufficient detail regarding training of community provider staff, collaboration with community clinicians, and the assessment of settings by SSLC clinicians. The lists of pre and post move supports were not comprehensive and all inclusive.
- Post move monitoring was done thoroughly, on time, and in all settings. Issues and problems were identified and followed through to resolution. The PMM involve the IDT, provider, facility clinicians, and/or APC as necessary. She was a strong advocate for the individuals.

Guardianship and Consent

- The facility had engaged in many activities towards assessing the need for guardianship and in obtaining guardianship. Examples included updating of lists, adding criteria, presenting to community groups, working with the courts, and continuing the guardianship committee.
- IDTs continued to need training to determine each individual's functional capacity to render informed decisions. An adequate tool was not yet developed.
- A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.

Recordkeeping Practices

- The recordkeeping department at LSSLC maintained substantial compliance with provisions V1 and V3. Progress was seen in provisions V2 and V4.
- The URCs sought out and worked with various discipline heads when needed, such as nursing, behavioral health services, and habilitation. Attention to detail, follow-up, and working with the facility's many disciplines was evident in the many email chains, meeting minutes, handouts, etc. shared with the monitoring team.
- Fifteen of 15 (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. An individual notebook existed for each individual. A master record existed for every individual at LSSLC and all were in a format that was organized and manageable.
- Five (or more) reviews (audits) were conducted in each of the previous six months. Twenty-six reviews were conducted at LSSLC in the six-month period January 2014 through June 2014. They were neatly and clearly documented. Data continued to be summarized, analyzed, and used to make changes in recordkeeping practices.
- The facility continued to address the requirements of V4 and additional progress was noted.

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 #001.2
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: 18 records of physical or chemical restraint used in a crisis intervention for six 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><th>Duration</th></tr>
<tr><td>#410</td><td>Physical/Chemical</td><td>5/7/14</td><td>70 min</td></tr>
<tr><td>#410</td><td>Physical/Mechanical Chemical</td><td>4/26/14</td><td>31 min</td></tr>
<tr><td>#410</td><td>Physical/Mechanical Chemical</td><td>4/24/14</td><td>135 min</td></tr>
<tr><td>#410</td><td>Physical/Mechanical Chemical</td><td>4/12/14</td><td>55 min</td></tr>
</table>
</td></tr>
</table>

#410	Physical /Mechanical Chemical	4/9/14	186 min
#170	Physical/Chemical	6/28/14	138 min
#170	Physical	6/26/14	4 min
#170	Physical	6/20/14	13 min
#170	Physical	6/17/14	15 min
#170	Physical	5/13/14	15 min
#333	Physical/Mechanical	7/2/14	4 min
#333	Physical/Mechanical	7/1/14	16 min
#333	Mechanical	6/10/14	10 min
#203	Physical	5/14/14	2 min
#313	Physical	5/12/14	12 min
#181	Chemical	5/7/14	n/a
#181	Chemical	5/1/14	n/a

- 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, 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
#454	5/13/14
#178	5/13/14
#33	5/14/14
#574	5/15/14

- 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 18, involving three individuals. Sample size was eight, 44% of the chemical restraints and 67% 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	5/7/14
#410	4/26/14
#410	4/24/14
#410	4/12/14

#410	4/12/14
#410	4/9/14
#170	6/28/14
#181	5/7/14
#181	5/1/14

- Sample #C.5: Restraints off-campus. The facility reported none.

Individual	Date
N/A	

- Sample #C.6: Positive Behavior Support Plans (PBSPs), Crisis Intervention Plans, and relevant ISPA meeting minutes for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:
  - Individual #170, Individual #410, Individual #333

- Sample #C.7 was chosen from the list of 10 individuals for whom protective mechanical restraints were used in the past six months for medical reasons. This included review of Protective Mechanical Restraint Plans (none found), Individual Support Plan (ISP), ISP Addendums, and ISP Action Plan.

Individual	Restraint type
#513	Seat belt and bedrails
#85	Mittens

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

Observations Conducted:
- Observations at residences and day programs
- Incident Management Review Team Meeting 7/14/14 and 7/17/14
- ISP preparation meeting for Individual #116 and Individual #163
- Annual IDT Meeting for Individual #344 and Individual #417
- Castle Pine Unit Meeting 7/15/14
- Castle Pine LOS and Protective Device Review 7/15/14
- Morning Clinical Services Meeting 7/17/14
- Executive Safety Committee Meeting 7/17/14
- Restraint Reduction Committee Meeting

	Facility Self-Assessment: LSSLC submitted its self-assessment. It was updated on 6/24/14. 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 12 out of 134 (9%) crisis intervention restraints from 1/1/14 through 5/31/14 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, C5, C6, C7, and C8. The facility found that the IDTs were not yet discussing and implementing desensitization strategies for individuals who required pretreatment sedation (C4). The monitoring team had similar findings for C4. Based on the samples reviewed, the monitoring team could not confirm compliance with C1, C2, C5, and C6.
	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 180 restraints used for crisis intervention involving 18 individuals between 1/1/14 and 5/31/14. The number of restraint incidents had increased since the last onsite review when it was reported that there had been 138 restraints during the review period. Individual #410 accounted for 108 of the 180 (60%) restraints used for crisis intervention. While the number of restraints had increased significantly for this one individual, the use restraints had decreased for other individuals at the facility. A log of all dental/medical restraints provided by the facility included 55 instances of pretreatment sedation for routine dental/medical appointments for 42 individuals from 1/1/14 through 5/31/14. This appeared to be a reduction from the last six months, however, data collection was not consistent to allow for comparison. The facility reported that 14 individuals at the facility wore protective mechanical restraints (PMRs). This included helmets, mittens, and wristlets. The facility had begun reviewing the use of helmets in unit meetings. It still was not evident that restraint plans were being developed consistently to instruct staff in when to apply, remove, and monitor the restraint in compliance with state policies. Since the last review, the facility had conducted an interdisciplinary review of helmet use for 22 individuals to determine the purpose of use. Eighteen of those were being used for protection from injury during seizures and falls. Each unit was regularly reviewing the use of helmets and developing strategies to minimize use when appropriate. A new ISPA form was developed with prompts for discussion to review

	the use of restrictive devices. The monitoring team encourages the facility to continue to review all restrictive devices to ensure that they are the least restrictive treatment method, safely used, carefully reviewed and monitored by the IDT, applied the minimal amount of time deemed necessary, and faded when no longer appropriate. Additional training was provided by the Behavioral Services Department in February 2014 regarding the use of restraints for crisis intervention. This included training on: • Restraint documentation, • Restraint prevention, and • De-escalation techniques. In efforts to increase desensitization and collect accurate data on progress, behavioral health staff attended dental appointments with individuals that historically required restraint use for dental appointments. This included 29 individuals. Ten individuals were identified by dental staff as needing desensitization plans. All 10 were included in the list of individuals that behavioral health services had targeted for data collection. A new format that included prompts for discussion was developed for ISPAs regarding medical and dental restraints. 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 Director of Behavioral Health Services was responsible for monitoring the requirements of section C. The state office had provided additional 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</td><td>According to a list of all restraints implemented at the facility (Document II.5),

<table><tr><th>Type of Restraint</th><th>July 2013-December 2013 (six months)</th><th>January 2014-May 2014 (five months)</th></tr><tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>130</td><td>118</td></tr><tr><td>Chemical restraints during a behavioral crisis</td><td>8</td><td>18</td></tr><tr><td>Mechanical restraints during a behavioral crisis</td><td>5</td><td>44</td></tr><tr><td>TOTAL restraints used in behavioral crisis</td><td>138</td><td>180</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

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.

TOTAL individuals restrained in behavioral crisis	18	18
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	8	11
Medical/dental pretreatment restraints	216 (Data available through Nov 2013 only)	55
TOTAL individuals restrained for medical/dental treatment	86 (Data available through Nov 2013 only)	42
Protective mechanical restraints	44 individuals	14

Prone Restraint

a. Based on facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (list of all restraints between 1/1/14 and 5/15/14) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 1/1/14 and 7/15/14. Sample #C.1 was a sample of 17 restraints instances for six individuals, representing 33% of the individuals involved in restraints. Some restraint instances in the sample included the use of two or more methods of restraint (i.e., horizontal hold and chemical restraint). The sample included 14 physical restraints, seven mechanical restraints, and eight 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.

Other Restraint Requirements

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

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		review: • f. In 17 of the 17 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • g. For the 17 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 17 (100%) 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. • h. In 17 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. • i. Facility policies identified a list of approved restraints. • j. Based on the review of 17 restraints, involving six individuals, 17 (100%) were approved restraints. k. In 17 of 17 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. l. The facility reported that there were 14 individuals subjected to protective mechanical restraints (PMRs). Nine of those had mittens, four had helmets, one had wristlets, and one had bedrails. Three were helmets used for crisis intervention and 10 were classified as medical restraints by the facility. The facility reported that the Behavioral Health Services Department had developed PMRPs for three individuals with PMRs used for crisis intervention to include a schedule of release, monitoring guidelines, and strategies for decreasing the use of the restraint. Those plans were not submitted for review. Sample C.7, a sample of documentation for two protective mechanical restraints (Individual #85 and Individual #513) was reviewed. These were categorized as medical restraints by the facility. Of these, zero (0%) followed state policy regarding the use, management, and documentation of PMR. 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. 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. • Individual #513 had bed rails to prevent him from getting out of his wheelchair and bed while he was wearing a cast for a recent leg fracture. DSPs were	

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		documenting the bedrails and seat belt on a medical restraint checklist, however, there was not a plan as required by state policy and the Settlement Agreement. • Individual #85 was wearing mittens to prevent "scratching and rubbing of eye." His restraints were also documented on medical restraint checklist. A restraint plan was not submitted to the monitoring team. The facility showed progress towards compliance with C1 regarding the documentation of restraints used for crisis intervention. Plans will need to be developed to address all protective mechanical restraints to prevent self-injurious behaviors following medical procedures. 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 all IDTs are holding adequate discussion regarding the use of protective mechanical restraints. 2. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 14 physical restraint records involving the five 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 seven restraints (50%) in the sample were over 15 minutes in duration; four restraints lasted over one hour with the longest lasting over three hours. • Individual #410 had a crisis intervention plan. The plan did not include a maximum duration for restraint as required by state policy (Use of Restraints – Policy #001.2). His five restraint incidents in the sample ranged from 31 minutes to 186 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. All five restraint incidents included the use of a helmet for self-injurious behavior. He did not have a plan in place with instructions for applying the helmet that included an active schedule for removing and replacing the mechanical restraint, as required by state policy. • Individual #170's crisis intervention plan did not include a maximum duration for restraint as required by state policy (Use of Restraints – Policy #001.2). He was restrained for 138 minutes on 6/28/14. Documentation for the restraint did not include sufficient description of his behavior to determine if the continued need for restraint was justified. • Individual #333's Crisis Intervention Plan did not include a limit set for the	Noncompliance

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		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 #333), 14 of 14 (100%) 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. b. For the individual who did not have Crisis Intervention Plans, two of two (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 include instructions regarding the maximum time that an individual can remain in restraint.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. A sample of 20 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 19 of the 20 (95%) had current training in RES0105 Restraint Prevention and Rules. The one employee that did not complete RES0105 completed RES0110. • 16 of the 17 (94%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. See comment above regarding the exception. • 20 of the 20 (100%) had completed PMAB training within the past 12 months. • 17 of the 17 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training.	Substantial Compliance

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		d. In 17 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. (see C.1.h)	
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 17 restraint records (Sample #C.1), in 17 (100%) 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 17 of 17 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 55 restraints were used to complete routine medical appointments from 1/1/14 through 5/15/14. The facility provided a sample of four restraints used to complete routine medical or dental treatment (Individual #454, Individual #33, Individual #574, and Individual #178). There was no evidence that the restraint used was in contradiction to the individual's medical orders according to the "Do Not Restrain" list. f. In 17 of 17 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 for individuals for whom restraint had been used for the completion of medical or dental work: In efforts to increase desensitization and collect accurate data on progress, behavioral health staff attended dental appointments with individuals that historically required restraint use for dental appointments. This included 29 individuals. Ten individuals were identified by dental staff as needing desensitization plans. All 10 were included in the list of individuals that behavioral health services had targeted for data collection. A new format that included prompts for discussion was developed for ISPAs regarding medical and dental restraints. The four individuals from Sample #C.3 were not on the list of individuals to be assessed for a desensitization program. • g. Zero (no documentation submitted) showed that there had been appropriate	Noncompliance

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		authorization (i.e., Human Rights Committee (HRC)) approval and adequate consent. • h. Zero 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. Based on this review, the facility was not in substantial compliance with C4. To gain substantial compliance, the facility needs to provide documentation 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 and developed desensitization strategies when appropriate.	
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	a. Review of facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. Restraint Monitor training included training specific to monitoring of a restraint incident. According to a list provided by the facility, 29 restraint monitors had 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 in the sample, 29 (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. Based on a review of restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In 17 out of 17 incidents of restraint (100%) by an adequately trained staff member. Additional training was provided for restraint monitors on 2/19/14. • e. In 16 out of 17 instances (94%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. The exception was Individual #333 on 6/10/14 at 10:50 am. The restraint monitor arrived 70 minutes after the restraint began. • f. In 17 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 17 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint. 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.	Noncompliance

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	signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	• h. In (n/a), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In (n/a), the alternative monitoring schedules were followed. Based on a review of 17 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 11 (65%) of the instance of restraint. Exceptions were: o Individual #410 on 5/7/14 o Individual #410 on 4/12/14 o Individual #410 on 4/9/14 o Individual #170 on 6/28/14 o Individual #170 on 6/17/14 o Individual #333 on 7/2/14 • k. Monitored and documented vital signs in 17 (100%). • l. Monitored and documented mental status in 17 (100%). Based on documentation provided by the facility, zero restraint incidents had occurred off the grounds of the facility in the last six months. 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 four out of four of the medical restraints (100%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Based on this review, the facility was not in substantial compliance with this provision. To gain substantial compliance with the requirements of C5, the facility will need ensure that: 1. 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.	

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C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 17 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 17 (100%), continuous one-to-one supervision was provided; • b. In 17 (100%), the date and time restraint was begun; • c. In 17 (100%), the location of the restraint; • d. In 17 (100%), 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 17 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. • f. In 17 (100%), the specific reasons for the use of the restraint; • g. In 17 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • h. In 17 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 17 (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 240 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. Six physical restraints in the sample lasted over 30 minutes. • l. In 17 (100%), the level of supervision provided during the restraint episode; • m. In 14 of 14 physical restraints (100%), the date and time the individual was released from restraint; and • n. In 17 (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 17 records (Sample #C.1), restraint debriefing forms had been completed for 17 (100%). p. A sample of four individuals subject to pretreatment sedation for medical treatment	Noncompliance

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		was reviewed (Sample #C.3), and in four (100%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. Sample #C.4 was a subsample of the eight chemical restraints included in Sample #C.1. q. In eight (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist 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. Staff were not documenting 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.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to LSSLC documentation, during the six-month period prior to the onsite review, a total of five individuals were placed in restraint more than three times in a rolling 30-day period. This represented a decrease from the last review when seven individuals were placed in more than three restraints in a rolling 30-day period. Three of these individuals (i.e., Individual #170, Individual #410, and Individual #333) were reviewed (60%) 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 results of this review are discussed below with regard to sections C7a through C7g of the Settlement Agreement. This item was rated as in noncompliance because the ISPAs reviewed did not consistently reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors, and if they are hypothesized to be relevant to the behaviors that provoke restraint, an action plan for modifying them to prevent the future probability of restraint. Individual #410's and 170's ISPA minutes reflected a discussion of their adaptive skills, biological/medical status, and psychosocial factors. These minutes, however, did not	Noncompliance

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		clearly indicate if the treatment team hypothesized if any of these factors affected their target behaviors that provoked their restraints. Simply listing these factors is not likely to be useful for 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.	
	(b) review possibly contributing environmental conditions;	This item was rated as in noncompliance because the available ISPAs reviewed did not consistently reflect a discussion of potential contributing environmental factors (e.g., setting events, such as 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 setting events, 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;	This item was rated as being in noncompliance because none of the ISPAs reviewed reflected a discussion of potential antecedents (placing of demands, reassignment of a preferred staff, etc.) 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;	This item was rated as being in noncompliance because none of the ISPAs reviewed consistently reflected a discussion of the variables potentially maintaining the behavior provoking restraints. 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 provoke restraint. Additionally, if environmental consequences are identified to affect the target behaviors that provoke restraint, the ISPA minutes should also reflect an	Noncompliance

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		action to address this potential source of motivation for the target behaviors.	
	(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;	This item was rated as in substantial compliance in the last review, however, it is now rated as noncompliance because one of the three (33%) PBSPs reviewed did not have all the necessary components listed below, and one of the three (33%) CIPs reviewed did not specify the maximum duration of restraint. 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 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 • Two (Individual #170 was the exception) of the three of the PBSPs reviewed (67%) 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 two (Individual #170 was the exception) of the three (67%) 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. In order to achieve compliance with this item a PBSP and crisis intervention plan will need to be presented for each individual having more than three restraints in a rolling 30-day period. Additionally, at least 85% of these individuals' PBSPs and crisis intervention plans will need to contain the above components.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant	There was improvement in this area, however, because treatment integrity data for one of the three individuals reviewed (33%) indicated that the PBSP was not implemented with integrity, this item was rated as noncompliance.	Noncompliance

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	treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	All three individuals reviewed had treatment integrity data. This represented a dramatic improvement from the last review when none of the individuals reviewed had data measuring the degree to which the PBSPs were implemented as written. Treatment integrity data for Individual #333, however, indicated that the last measure of treatment integrity (and two of the three measures collected in the last year) was below the goal level established by the facility (see K4). When a treatment integrity level falls below that acceptable to the facility, the staff should be retrained, and another treatment integrity session conducted to assess if staff are now implementing the plan with integrity. In order to achieve substantial compliance with this provision item, LSSLC needs to 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 (i.e., at or above the goal treatment integrity level).	
	(g) as necessary, assess and revise the PBSP.	This item was rated as noncompliance because none of the ISPAs reviewed documented that the treatment team reviewed the PBSP. 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 psychologist, 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 17 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 17 (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 17 (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 17 (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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• d. In 17 (100%), the review conducted by the restraint monitor and/or psychologist 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 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.	

<table>
<tr><th>SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management</th><th></th></tr>
<tr><td>Each Facility shall protect individuals 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>:

- Section D Presentation Book
- LSSLC Section D Self-Assessment
- DADS Policy: Incident Management #002.4, dated 11/20/12
- DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12
- Incident Management Review Committee meeting minutes for each Monday of the past six months
- Executive Safety Committee meeting minutes
- Acknowledgement to report abuse for all employees hired within the last 2 months
- Abuse/Neglect/Exploitation Trend Reports for the past two quarters
- Injury Trend Reports for the past two quarters
- Injury reports for three most recent incidents of peer-to-peer aggression incidents
- List of all serious incidents and injuries since 6/1/13
- All injury report for the past six months for any individual sustaining a serious injury.
- Injury Audits for:
  - Individual #580, Individual #47, Individual #11, Individual #520, Individual #540, Individual #12, Individual #344, Individual #319, Individual #321, Individual #22, Individual #45, Individual #402, Individual #422, and Individual #62.
- A sample if ISPs for
  - Individual #402, Individual #470, Individual #170, Individual #418, Individual #526, Individual #551, Individual #410, Individual #60, and Individual #128.
- List of all ANE allegations since 6/1/13 including case disposition
- A list of all investigations completed by the facility in the last six months.
- List of employees reassigned due to ANE allegations
- List of staff who failed to report ANE or failed to report in a timely manner
- Training transcripts for the past two years for a random sample of 20 employees
- Training transcript (trainings completed and dates of completion) for anyone at the facility responsible for unusual incident investigations.
- Documentation from the following completed investigations, including follow-up:

Sample D.1.	Allegation	Disposition	Date/Time of APS Notification
#43130784 UIR #14-129	Physical Abuse	Unconfirmed	5/11/14 5:38 pm
#43130758 UIR #14-128	Physical Abuse (5)	Unconfirmed (5)	5/11/14 4:18 pm

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#43120512 UIR #14-120	Neglect	Confirmed	5/2/14 3:59 pm
#43110319 UIR #14-118	Physical Abuse	Unconfirmed	4/24/14 5:17 pm
#43102250 UIR #14-112	Physical Abuse (3)	Confirmed (3)	4/17/14 6:04 pm
#43096683 UIR #14-108	Neglect Physical Abuse	Confirmed Confirmed	4/14/14 10:35 am
#43132594 UIR #14-130	Neglect	Clinical Referral	5/13/14 8:32 am
#43127546 UIR#14-125	Emotional/Verbal Abuse	Referred Back	5/8/14 12:38 pm
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**
UIR #14-99	Sexual Incident	4/24/14 11:04 M	4/24/14 11:04 AM
UIR #14-96	Serious Injury	4/3/14 Unknown	4/3/14 8:30 pm
UIR #14-94	Serious Injury	3/29/14 5:25 pm	3/29/14 5:40 pm
UIR #14-92	Serious Injury	3/25/14 10:50 pm	3/26/14 9:45 am
UIR #14-83	Unauthorized Departure	3/3/14 8:07 pm	3/3/14 8:07 pm

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
- Stephani Sowell, Acting QIDP Coordinator
- Gail Husband, ADOP
- Stephen Webb, HRO

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 7/14/14 and 7/17/14
- ISP preparation meeting for Individual #116 and Individual #163
- Annual IDT Meeting for Individual #344 and Individual #417

	o Castle Pine Unit Meeting 7/15/14 o Castle Pine LOS and Protective Device Review 7/15/14 o Morning Clinical Services Meeting 7/17/14 o Executive Safety Committee Meeting 7/17/14
	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. The facility's review of its own performance found compliance with 21 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 17 of the 20 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 and D3i. While the monitoring team agreed that progress had been made with both of these provisions, the facility was not yet in substantial compliance. Ratings for D4 were similar for the self-assessment and the monitoring team's review (i.e., noncompliance).
	Summary of Monitor's Assessment: According to a list provided by LSSLC, DFPS conducted 40 investigations involving 64 allegations at the facility between 2/1/14 and 7/11/14, including 30 allegations of physical abuse, 20 allegations of verbal/emotional abuse, one allegation of sexual abuse, and 13 allegations of neglect. Of the 64 allegations, there were eight confirmed cases of physical abuse, one confirmed cases of verbal/emotional abuse, four confirmed cases of neglect, and no confirmed case of exploitation. The facility reported that 22 other serious incidents were investigated by the facility during this period. There were a total of 1268 injuries reported between 12/1/13 and 5/31/14. These 1268 injuries included 15 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 had been a decrease in both the total number of injuries and the number of serious injuries reported the previous six months. The monitoring team noted concerns related to the high number of injuries attributed to mobility during the last monitoring

	visit. Of the 1268 injuries reported, 368 were attributed to mobility including bumping into objects, slips, trips, falls, and injuries during transfers. This was a decrease from the 407 mobility related injuries the previous six months. The facility continued to focus on reducing the number of mobility related injuries. 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 an Executive Safety Committee to review trends of injuries and incidents. The committee was now formalizing recommendations into action plans with specific steps that could be monitored for implementation. The committee had just begun using data to track outcomes. The parties agreed that there be no monitoring for two 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 17 of the 20 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. Further, the facility should implement appropriate follow-up to findings (i.e., complete a CIR for injuries not reported). • D.3.i: The facility was not documenting implementation of recommendations and 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 not yet following up on action plans to address trends to determine if desired outcomes were achieved. IDTs were still not adequately addressing trends of injuries and incidents.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The 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
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement		

#	Provision	Assessment of Status	Compliance
	incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. According to a list of all abuse, neglect, and exploitation investigations provided in response to document request III.TT.6, there were 40 completed investigations involving 64 allegations of abuse, neglect, or exploitation conducted by DFPS at the facility between 2/1/14 and 7/11/14. From these 64 allegations, there were: • 30 allegations of physical abuse including, o 8 confirmed o 17 unconfirmed o 3 inconclusive o 2 referred back for further investigation • 20 allegations of verbal/emotional abuse including, o 1 confirmed o 10 unconfirmed o 5 inconclusive o 2 referred back for further investigation o 1 unfounded o 1 outcome unknown • 1 allegations of sexual abuse including o 1 unconfirmed • 13 allegations of neglect including, o 4 confirmed o 6 unconfirmed o 1 inconclusive o 1 referred back to the facility for further investigation o 1 clinical referral • 0 allegations of exploitation According to a list provided by the facility, there were 22 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• 9 serious injuries/determined cause, • 2 serious injuries from peer-to-peer aggression, • 0 serious injury/undetermined cause • 2 sexual incidents, • 1 choking incident, • 0 suicide threats, • 0 encounters with law enforcement, • 4 unauthorized departures, • 2 deaths, and • 2 other (unknown). From all investigations since 2/1/14 reported by the facility, 13 investigations were selected for review. The 13 comprised two samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. This sample represented 20% of all A/N/E investigations. See the list of documents reviewed for investigations included in this sample (8 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS. This sample represented 23% of all investigations not involving A/N/E. (5 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 reporting procedures for abuse, neglect, and/or exploitation.	

#	Provision	Assessment of Status	Compliance
		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 eight investigation reports included in Sample #D.1: • Metric 2.a.6: Six (75%) 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. o DFPS case #43120512 involved an unauthorized departure at 11:40 am due to a breach of supervision. DFPS was not notified until 3:59 pm. The unauthorized departure should have been immediately investigated by the facility and reported to DFPS. o DFPS case #43102250 involved confirmed allegations of physical abuse witnessed by another staff person. Staff did not report the incident for four days. She received disciplinary action for failure to report the incident in a timely manner. • Metric 2.a.7: Eight (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o Seven of eight (88%) indicated the facility director or designee was notified of the incident within one hour. The exception was: ▪ For DFPS case #43132594, the facility was notified of an allegation of neglect at 9:42 am on 5/13/14. The director was notified at 10:45 am on 5/13/14. o Eight of eight (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o Eight of eight (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, one UIR (50%) included recommendations for corrective actions. Based on a review of five investigation reports included in Sample #D.2: • Metric 2.a.9: Five (100%) 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: Five (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	

#	Provision	Assessment of Status	Compliance
		IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folders included recommendations for corrective actions. (n/a) 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. Metric 2.a.13: Based on a review of 13 investigation reports included in Samples #D.1 and #D.2, 13 (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. Forty-one of 41 (100%) new employees hired between 4/1/14 and 5/31/14 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 2/1/14 and 6/1/14. The log included the applicable investigation case number, and the date the employee was returned to work. The log did not indicate when the employee was reassigned. Based on a review of investigation reports included in Sample D.1, in seven out of seven cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. In seven out of seven cases (100%), where there was a known alleged perpetrator, there was no evidence that the employee was returned to his or her previous position prior to the completion of the investigation or when the employee posed no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the eight investigation files in Sample D.1, eight (100%) 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		assessment by a nurse, and an emotional assessment. The facility was in substantial compliance with this provision.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included three employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • There was evidence that 18 of the 21 (72%) employees with current training who had been employed over one year had completed the ABU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • There was evidence that 18 of the 21 (72%) employees with current training who had been employed over one year had completed the UNU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. Based on this review, the facility was in substantial compliance with the requirement for annual training, however, the facility needs to continue to focus on ensuring that employees are retrained annually as required by the Settlement Agreement and state policy.	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 evidencing their recognition of	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter after completing ABU0100 training. A sample of this form was reviewed for a random sample of 20 employees at the facility. 20 (100%) of 20 employees in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The facility reported that there was one case where staff failed to report abuse or neglect as required. The employee received performance counseling. DFPS case #43120512 involved an unauthorized departure at 11:40 am on 5/2/14 due to a breach of supervision. DFPS was not notified until 3:59 pm that day. The unauthorized departure should have been immediately investigated by the facility and reported to DFPS. The facility identified nine additional employees who failed to report within required timelines. The list provided to the monitoring team indicated that all nine employees received performance counseling. The monitoring team assigned a substantial compliance rating to this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. It was a clear and easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. A sample of nine ISPs was reviewed for compliance with this provision. The sample ISPs were for Individual #402, Individual #470, Individual #170, Individual #418, Individual #526, Individual #551, Individual #410, Individual #60, and Individual #128. • Nine (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. The facility was in substantial compliance with this item.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	report violations of such rights.	Observations by the monitoring team of living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with her name, picture, and contact information. The HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group. The facility remained in substantial compliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of eight allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and/or OIG of the allegation in seven (100%), when appropriate. OIG investigated four cases in the sample and criminal activity was substantiated in two of four (50%) cases. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • LSSLC Policy addressed this mandate by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of LSSLC. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this occurred. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. No names were submitted. Based on a review of investigation records (Sample #D.1), there were concerns related to potential retaliation for reporting in one case. The witness in DFPS case #43102250 stated that she was hesitant to report the allegation for fear of retaliation by staff involved. She was moved to a different work location following the investigation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility maintained substantial compliance with this item.	
	(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. Forty files were chosen to be audited during the past six months. 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. A review of a sample of injury audits indicated that client injury reports were not always completed on injuries documented in progress notes. Auditors did not comment on injuries not documented with a CIR regarding probable cause of injury or recommend further investigation in any of the audits reviewed. Although auditors noted that CIRs were not filed, auditors did not recommend that client injury reports were completed on those injuries. Without completion of a CIR, circumstances of the injury and data summaries regarding the number of injuries for each individual were not accurate. For example, • An injury audit conducted for Individual #580 on 3/22/14 noted three documented injuries. CIR report data indicated that he had one injury during the time period reviewed. The auditor checked "no action necessary" on the action to be taken as a result of the audit. If CIRs were not completed following the review, data reviewed by the IDT regarding injury would not be accurate. • An injury audit for Individual #319 indicated that documentation was found for injuries not reported using a CIR. The auditor noted that documentation of injuries was inconsistent in the IPN, staff observation notes, CIRs, and unit meeting minutes. The auditor checked "no action needed" on the action form. 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)	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 investigator investigated all serious injuries. Findings were reviewed by the facility at daily IMRT meetings. To move towards compliance with D2i, 1. 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. 2. The facility had developed an injury audit system, however, the facility should implement appropriate follow-up to findings (i.e., complete a CIR for injuries not reported). When problems are identified during the audit with documentation and/or investigation of injuries, action should be taken to correct the problem identified and completion of follow-up should be documented.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on conducting investigations and working with people with developmental disabilities. LSSLC had 19 employees designated to complete investigations. This included the IMC, Facility Investigators, and Campus Administrators. The training records for those designated to complete investigations were requested, 10 (100%) investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, and • Comprehensive Investigator Training.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that staff did not cooperate with any outside agency conducting investigations. The facility incident management coordinator reported good cooperation between the facility incident management staff and DFPS.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	Based on a review of the investigations completed by DFPS, the following was found: • Of the eight investigations completed by DFPS (Sample #D.1), OIG investigated four of the incidents. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The LSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video surveillance was in place throughout LSSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within	<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 two investigations referred back to the facility for further review were not used in this sample).	Substantial Compliance

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	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.	○ Contact with the alleged victim occurred within 24 hours in three of six (50%) investigations. Exceptions were DFPS cases #43120512, #43110319, and #43096683. ○ 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, six of eight (75%) were completed within 10 calendar days of the incident. DFPS case #43130758 was signed by the DFPS investigator on the 10th day, however, the facility UIR indicated that the report was not received for review until the 17th day. Extensions were filed for two investigations. The investigations not completed within 10 days: ○ Case #43102250 was submitted on the 28th day (delayed for OIG investigation). ○ Case #42096683 was submitted on the 18th day (delayed for OIG investigation). • All eight (100%) resulted in a written report that included a summary of the investigation findings. • In six of eight (75%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Two 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 four of five cases (80%). ○ For UIR #14-94, it was not possible to determine if the investigation began within 24 hours. Investigation activities with timelines were not documented in the UIR. The UIR gave a chronological narrative of the incident, however, failed to document investigation activities. No witness statements were documented. • Five of five (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Four of five (80%) included appropriate recommendations for follow-up action to address the incident. ○ UIR #14-94 was a serious injury that occurred when the individual rolled off of his bed. The nurse noted that "he rolled off his bed onto the mats in front of his bed several times, and the last time hit his mouth on the floor." The individual's profile noted that he should be monitored when in his room every 15 minutes and should have some form of	

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		redirection tool available at all times. It was not evident that supports were implemented as written. There was no indication that staff completing 15 minute checks attempted to engage him in activity to reduce the noted behavior. The UIR did not include recommendations to address this in order to reduce the probability of a similar injury occurring. The facility was in substantial compliance with the requirement of D3e.	
	(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	Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In eight out of eight investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o In eight (100%), each unusual/serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of all alleged victims and perpetrators; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In eight (100%), all documents reviewed during the investigation; o In eight (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS found in each case that prior case history of principals was reviewed and used or not used in the current investigation. Facility UIRs included a summary of previous similar investigations with a statement regarding the outcome of those investigations. o In eight (100%), the investigator's findings; and o In eight (100%), the investigator's reasons for his/her conclusions.	Substantial Compliance

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	his/her conclusions.	<u>Facility Investigations</u> The following summarizes the results of the review of five facility investigations: • The report utilized a standardized format that set forth explicitly and separately: o In five (100%), each unusual/serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all witnesses; o In five (100%), the name(s) of all alleged victims and perpetrators; o In five (100%), the names of all persons interviewed during the investigation; o In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In five (100%), all documents reviewed during the investigation; o In five (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In five (100%), the investigator's findings; and • In five (100%), the investigator's reasons for his/her conclusions. • In five out of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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. <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	Substantial Compliance

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		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, • Eight (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • Eight (93%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In five out of five 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 subparagraph g, for each unusual incident.	A uniform UIR was completed for 13 out of 13 (100%) unusual incidents in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding	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 was using an action tracking log to track follow-up to recommendations. The log included a date that recommended action was completed and a review date that the implemented action was monitored for effectiveness.	Noncompliance

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	outcomes.	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 six cases: • Four DFPS cases: #43096683, #43120512, #43102250, #43130758; and • Two facility investigations: UIR #14-94 and #14-93 Metric 3.i.3: For zero out of four (0%) of the DFPS investigations reviewed in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented. • In DFPS case #43130758, a recommendation was made for retraining one of the APs in regards to intervening in behavior incidents. The case file did not include documentation that retraining was completed. The facility UII tracking log indicated that training was completed on 5/29/14, however, there were no details included on the tracking form and no documentary evidence was submitted. • DFPS case #43102250 involved three confirmed allegations of physical abuse. The facility did not include recommendations for disciplinary action, nor was disciplinary action documented in the case file for the two staff with confirmed allegations. Documentation of disciplinary action taken in regards to one of the witnesses who failed to report in a timely manner was included in the case file. The UII Action Tracking Log included one broad recommendation to address all of DFPS's concerns. A completion date was listed, but did not indicate what action was taken. • DFPS case #43120512 was the investigation of a confirmed allegation of neglect. The UIR included one general recommendation for the unit director to address DFPS concerns. There was no documentation of follow-up included in the case file. The UII Action Tracking Log included the one broad recommendation with a completion date. There were no details given on how the facility completed that recommendation. • DFPS case #43096683 included confirmed allegations of physical abuse and neglect. The case file did not include documentation that disciplinary action occurred in regards to the incident. 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 zero out of three (0%) of the investigations in the subsample (DFPS #43102250, UIR #14-94, and UIR #14-92), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator.	

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		• For DFPS case #43102250, the DFPS investigator noted several concerns. The facility UIR included one broad recommendation to address the DFPS concerns. One concern noted by DFPS was that documentation of outings was not available for review. Documentation of follow-up to concerns noted "currently being modified to ensure tracking of outings and approval processes." No further documentation of follow-up was submitted. Another concern was noted by DFPS regarding the falsification of documentary evidence. The follow-up documentation noted "records will be corrected." No further documentation was submitted to show completion or action taken to ensure that this was not an ongoing problem. • UIR #14-94 included one recommendation regarding the lack of IDT follow-up in a timely manner following a serious injury. The investigation file included an ISPA regarding the incident. The ISPA, however, indicated that appropriate supports were in place and were effective. No further recommendations were made. The UIR narrative of the incident indicated that staff were not implementing supports that might have prevented the injury from occurring. Staff were directed to check on the individual every 15 minutes and redirect/engage him when agitated. Staff checked on the individual and noted that he was rolling off the bed onto the floor, but did not document interventions prior to his injury. The purpose of the IDT meeting following a serious injury should be to ensure that supports are effective and consistently implemented to prevent similar injuries from occurring. • UIR #14-92 was the investigation of a fall that resulted in a fractured leg. The investigator recommended that the team meet to discuss placing a sensor on his bed to alert staff when he gets up. The IDT met and decided to add bedrails and bolsters to his bed to keep him from being able to get out of bed. The ISPA noted that a sensor "would be added to alert staff when he gets out of bed, but for the time the cast is on, it will not be needed." During the review, staff in the home reported that he was sliding down in bed so that he can get past the bedrails and out of bed. There was no indication that the IDT had monitored preventative supports for effectiveness. Metric 3.i.5: For zero out of six 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 had developed an UII action tracking log to track completion and implementation of recommendations. In most cases, recommendations were too general to ensure adequate tracking and monitoring. Based on identified issues with the implementation of recommendations and desired	

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		outcomes, the facility remained out of compliance with this provision.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	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 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.	Noncompliance

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		Metric 4.9: The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion. This was a fairly new process for the facility. For most corrective action plans, there had not been enough time following implementation to determine if action was effective. Metric 4.10: The trend reports/minutes reviewed, as appropriate, the effectiveness of previous corrective actions. For most of the action plans implemented to address injuries and incidents, the facility was still in the implementation stage. Based on a review of resulting action plans included in QA/QI trend reports and documentation related to implementation: Quarterly trend reports did include action plans with specific outcomes related to trends identified. The facility had developed 85 action steps within a single CAP to address trends of injuries and incidents. • Metric 4.11: Action plans included in the quarterly trend report 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 the action plans reviewed, the plan appeared to have 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. The facility had just begun looking at outcomes related to action steps. The facility continued to make progress on identifying trends and developing corrective action plans to address trends of injuries and incidents. It was positive to see the efforts made by the incident management department in this area. As noted throughout this report, however, the monitoring team, continued to identify problems with IDTs quickly implementing and monitoring supports to prevent injuries and incidents. For example, • The incident management department had identified a trend of falls for Individual #90. She continued to appear on the list of individuals with the highest number of falls in quarterly trend reports. The QA/QI Committee and the Executive Safety Committee were reviewing her fall data due to the significant number of falls in the past year. A review of her file showed that the IDT failed to consistently review her fall data and follow-up on recommendations made to address her falls. On 6/20/14, the IDT met and reviewed her fall data (19 falls over the past year/7 falls in May 2014). There was no indication that the team was monitoring her supports, met in a timely	

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		manner when she continued to fall, or revised supports when not effective. Her IDT submitted a referral to the PNMT on 6/18/14, at the time of the monitoring visit (a month later), the PNMT had still not addressed the referral. To move forward, the facility will need to ensure that as trends are identified and plans are implemented, 1. IDTs meet to review/revise supports and develop corrective action plans immediately when trends are identified. 2. Supports are monitored for consistent implementation. 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 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.	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 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>: ○ DADS policy #003.1: Quality Enhancement, dated 1/26/12, updated 5/22/13 with new DADS administrative staff names ○ LSSLC facility-specific policies (no changes since last review): • QA Processes, Administration, #14, 12/15/13 • QAQI Council, Committees/Councils, #2, 10/15/12 ○ LSSLC organizational chart, undated, but likely June 2014 ○ LSSLC policy lists, 5/20/14 ○ List of typical meetings that occurred at LSSLC, undated but likely June 2014 ○ LSSLC Self-Assessment, 6/30/14 ○ LSSLC Action Plans, 6/18/14 ○ LSSLC Provision Action Information, 6/18/14 ○ LSSLC Quality Assurance Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 7/14/14 ○ LSSLC DADS regulatory review reports, 12/19/13-6/18/14 ○ LSSLC QA plan narrative, 5/20/14 ○ LSSLC data listing/inventory, hard copy, 5/20/14 ○ LSSLC QA plan matrix, 5/16/14 ○ LSSLC Final Indicator lists, for each department, most recent updated 5/1/14 ○ Blank data collection review/addition document (one page) ○ List of all QA department staff and their responsibilities, undated, likely June 2014 ○ LSSLC QA department meeting notes, (none) ○ Set of blank tools used by QA department staff, revised June 2014 ○ Standard trend analysis reports for four areas, for two quarters ○ Sets of other data: satisfaction surveys, Woodland Crossing special project ○ QAD-SAC-1:1 meetings minutes, various typed, handwritten, and assorted attachments, seems to all be from April 2014 and May 2014 ○ LSSLC QA Reports, monthly, May 2014 to July 2014 (3) ○ QAQI Council minutes, semi-monthly, January 2014 to July 2014 (7 months, 14 meetings) • Handouts and agenda for meeting during onsite review, 7/16/14 ○ LSSLC Corrective Action Plan documents • Description of how data are used to initiate a CAP and how the CAP is disseminated • CAPs summary spreadsheet, updated 7/15/14 • 19 active/current CAPs, with CAP detail, action steps, and status updates • Sets of CAPs labeled as completed, modified, continued, and initiated since last review • Blank CAP action step spreadsheet • Emails to various staff regarding initiation and follow-up on CAP implementation, more

	than 500 pages Interviews and Meetings Held: o Gale Wasson, Facility Director o QA department: Gale Wasson, Darla Runnels, Sharon Ball, Robert Cheshire, Latoya Bennett, LaDonna Irwin Brooks, Paul Van, Shela Gibson, Dawn Stoltz o Unit directors and residential director: Todd Miller, Mary Stovall, Kenneth Self, Julie Olivares o Gale Wasson, Paul Vann, regarding sections G and H Observations Conducted: o QAQI Council meeting, 7/16/14 o Morning unit meeting, Oak Hill, 7/15/14 o Clinical services meeting, each morning
	Facility Self-Assessment The QA Director used the same self-assessment as used at the last review. This continued to provide her with a valid review of the progress of the QA department towards substantial compliance for all five provisions of this section. Given that this report has alpha-numerically labeled the metrics, this should provide further guidance to the QA director for her next self-assessment. That is, the QA director could use these metrics in her own self-assessment. If so, however, she should be sure to read all of the detail provided within the report for each metric because there is important supplemental information provided. The self-assessment again 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 QA director could also consider reducing the number of sets of graphs. These could instead be referenced and/or summarized. The facility self-rated itself as being in noncompliance with all sections E1, E2, and E5. The self-ratings for E3 and E4 were substantial compliance. The monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: The QA program at LSSLC made more progress than ever before. Numerous aspects of the program were improved, revised, or created. Substantial compliance was maintained for section E3 and obtained for section E4. The previous QA director left the facility in May 2014. The SAC was appointed to be the new QA director. She was scheduled to start in this position in the weeks following the onsite review. A lot of work was done by the QA director and the department heads to develop a list of what they called

	"Final Key Indicators" for each of the 20 sections of the Settlement Agreement. These lists appeared to be comprehensive. At the same time, the QA department maintained a data list inventory document. It did not line up with the content of the final key indicator list. Thus, the facility had two disparate lists of data. The new QA director needs to create a single data list inventory. The QA director and SAC held meetings in April 2014 with 11 different department heads that covered 14 of the Settlement Agreement provisions. The facility planned to re-start these meetings soon. The LSSLC QA report was initiated in May 2014. Of the 20 sections of the Settlement Agreement, 18 (90%) appeared in a QA report at least once each quarter in the last six months. Because QA reports were only recently created, the monitoring team included the data and slides presented at QAQI Council prior to the initiation of the QA reports in May 2014. The CAP system continued to develop and improve. CAPs were mentioned in numerous meetings attended by the monitoring team and were being implemented across the facility. The QA department assigned a program compliance monitor the responsibility for managing the CAPs. There were 19 open CAPs. They were related to 8 Settlement Agreement provisions. Of the 8 CAPs reviewed by the monitoring team, 8 (100%) appeared to appropriately address the specific problem for which they were created. 6 of the 8 (75%) had measurable criteria (i.e., the newer CAPs). 8 of the 8 (100%) CAPs looked at assessing outcomes to ensure that the problem originally identified was remedied or reduced. The QA PCM kept a detailed spreadsheet that summarized the status of all CAPs and their action steps. She reported to QAQI Council on the status of the CAPs.

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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.	During this review period, the QA program at LSSLC made more progress than ever before. Numerous aspects of the program were improved, revised, or created. About six weeks prior to the onsite review, the QA director, Paula McHenry, left the facility for another job. Since then, the facility director took responsibility for the QA program. During the week of the onsite review, the Settlement Agreement Coordinator, Dawn Stoltz, was appointed as the new QA director. She was scheduled to begin in her new position in the weeks following the onsite review. The other members of the QA department remained the same, plus there was the addition of one program monitor. The QA staff had various responsibilities that were assigned in a thoughtful manner, such as managing policies, providing QA nursing, managing regulatory issues, overseeing corrective action plans, and creating and managing databases. All of this helped to support consistency and progress. QA staff meetings were not being held.	Noncompliance

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		Policies 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, updated 5/22/13. The monitoring team's comments on the state policy are in previous monitoring reports and are not repeated here. b. There were not facility policies that adequately supported the state policy for quality assurance. Facility policies had not been updated. The QA director could consider the QA plan narrative as an addendum to a new facility policy regarding QA. Quality Assurance Data List/Inventory c. There was not yet a complete and adequate data list inventory at the facility. A lot of work was done by the QA director and the department heads to develop a list of what they called "Final Key Indicators" for each of the 20 sections of the Settlement Agreement. These lists appeared to be comprehensive. Most were very lengthy (e.g., psychiatry had 76 items, habilitation was 14 pages). Some of the indicator lists included data that that the department planned/wanted to collect, but had not yet started (this indicated good planning). At the same time, the QA department maintained a data list inventory document. It did not line up with the content of the final key indicator list. Thus, the facility had two disparate lists of data. The new QA director needs to create a single data list inventory. It may be that the content of the final key indicator list replaces the content of the current data list inventory database. She may choose to call it a final key indicator list, a data list inventory, or a key indicator inventory. It looked like the QA director was working towards this because the notes from the handful of QAD-SAC meetings in April 2014 had this on the agenda. Further, the self-assessment specifically stated that all of these lists were reviewed "to ensure that all match and are kept current" (self-assessment, item E1, #3, pages 38-39). The most recent final key indicator lists and data list inventories were dated late April 2014, so it may be that the work was not yet completed and/or the listings were not yet updated. Ultimately, this list should include all of the data collected by the department. Then, a subset of these items is chosen for the QA matrix, inclusion in the QA report, and presentation to QAQI Council. At this time, these three aspects of the QA program did not line up (i.e., the same items were not in the indicator/inventory list, matrix, and QA report/QAQI Council presentation).	

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		The good news is that the new QA director had a lot of information that she can use. The work of the previous QA director and department heads resulted in extensive lists of data items. This does not need to be re-created. As she finalizes the listings, the QA director and department heads should continue to ensure that the following are addressed in the creation of a single key indicator data list inventory: • no important items are missing from the inventory • process and outcome indicators are included • data are being collected as per the wording of section E1 • all content, metrics, data in the monitoring team's report are included d. The data list inventory was current. 20 of the 20 lists (100%) were updated within the past six months. Each inventory had its own date of update. That being said, the lists needed a new update to pull together the final key indicator list and the data list inventory. <u>Quality Assurance Plan Narrative</u> e. The QA plan narrative was not current, complete, and adequate. A description of the QAQI Council and its role in the QA program was needed. <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; most (but not necessary all) of these data are then included in the QA reports and presented to the QAQI Council. QA plan matrix items should include information regarding how the data for these items are to be collected, reviewed, and managed, such as frequency of data collection/summary, person responsible for review, and how data are to be presented. Because, as noted above, the LSSLC QA matrix did not line up with the final key indicator list or with what was presented in the QA report and to QAQI Council, the monitoring team cannot rate the remaining metrics of section E1, though some commentary is provided. f. There were items in the QA plan matrix for -- of the 20 sections (--%). The items represented a set of key indicators for -- of the 20 (--%). • There were items in the final key indicator list for all 20 sections. g. Of the 20, both process and outcome indicators were identified for -- of the 20 (--%) in the QA matrix. • The QA matrix had a format that required the labeling of each indicator as a	

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		process or outcome indicator. h. Of the 20, in -- (--%), the indicators provided data that could be used to identify the information specified in E1: "trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports." o The QA director should describe, for each section (perhaps in the QA matrix and/or in the 1:1 meeting minutes) how data were being collected and presented to identify trends across the variables described in the wording of E1. • Each of the final key indicator lists contained items that could be used in this manner. i. The QA matrix (did/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. • It should separate out the self-monitoring tool as a whole from its component parts. j. All data that QA staff members collected (were/were not) listed in the matrix. k. All of the items in the QA matrix (did/did not) appear in the QA data list inventory. QA Plan Implementation When the QA matrix includes detail regarding implementation, the following metrics will be assessed: 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 and 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. Self-Monitoring Tools Given that the QA department did not yet identify if self-monitoring tools were going to be used, the monitoring team did not evaluate these four metrics: p. Content/validity	

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		q. Adequate instructions r. Implementation s. QA review	
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.	Progress was seen at LSSLC regarding the gathering, organization, and analysis of data. In this section (E2), the monitoring team's findings are based upon the data that were included in the QAD-SAC 1:1 meetings documentation, in QA reports, and in QAQI Council meeting minutes. a. Data from the QA plan matrix for -- of the 20 (--%) sections of the Settlement Agreement were summarized. The QA matrix, as noted in E1, was not being used to guide what data were presented and reviewed. Even so, most sections presented some data at least once each quarter. • Few sections, however, analyzed data across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals. <u>Monthly QAD-SAC meeting with discipline departments</u> Meetings between the QAD-SAC and discipline department section leaders were not occurring regularly at LSSLC. The purpose of these meetings is to review the status of various aspects of quality assurance and quality improvement activities. At a minimum, each of the five bulleted items in metric b. below should be explicitly addressed at least once each quarter in this type of forum. b. Since the last onsite review, a meeting occurred at least twice for 0 of the 20 (0%) sampled sections of the Settlement Agreement. • 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. The QA director and SAC held meetings in April 2014 with 11 different department heads that covered 14 of the Settlement Agreement provisions. The facility shared meeting agendas, handouts, and handwritten notes with the monitoring team. c. Since the last onsite review, during 0 of the 11 (0%) meetings, data were available to facilitate department/discipline analysis of data. d. Since the last onsite review, during 0 of the 11 (0%) meetings, data were reviewed	Noncompliance

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		and analyzed. For the purposes of this metric, the monitoring team rates this as acceptable if there was review and discussion of data. e. Since the last onsite review, during 3 of the 11 (27%) 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> The LSSLC QA report was initiated in May 2014. Three reports were given to the monitoring team (May 2014, June 2014, and July 2014). Each QA report contained the data and presentation slides assembled prior to each QAQI Council meeting. The information in the QA report was what was presented at QAQI Council. 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 three of the last six months (50%). g. Of the 20 sections of the Settlement Agreement, 18 (90%) appeared in a QA report at least once each quarter in the last six months. Because QA reports were only recently created, the monitoring team included the data and slides presented at QAQI Council prior to the initiation of the QA reports in May 2014. Sections G and N appeared in one of the two quarters. h. Of the 20 sections of the Settlement Agreement that were presented quarterly, 0 (0%) contained all of the components listed below. • 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 - 20 of the 20 sections presented a variety of other key indicators and important data; this was good to see. There was a range from many items to just a few. - An area for improvement is to show data and trends across the variables listed in E1 (or indicate clearly a rationale for not doing so). This was done somewhat in about half of the sections. The variables presented were, for the most part, by unit or by discipline department/provider. o Data should not be presented for individual physicians along with their name.	

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		- The section E report should eventually include data on QA activities (e.g., from the QAD-SAC 1:1 meetings). - Data were probably available for 12 months or more for many indicators, however, many reports only showed data for the current month or current quarter. • Narrative analysis - There should be an analysis of the causes of the problems, not just a description of their occurrence. - The QA director and SAC might include a template for the section leader that prompts one paragraph for a <u>summary</u> of the data and a separate paragraph for the <u>analysis</u> of the data. - The content/data items of the QA report did not line up with what was in the data list inventories, QA matrix, or final key indicator list. <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 January 2014 through July 2014 (14 meetings). i. There was not an adequate description of the QAQI Council in the QA plan narrative. j. Since the last onsite review, the QAQI Council did meet at least once each month. The QAQI Council at LSSLC met twice per month. 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 all 14 of the QAQI Council meetings since the last review documented that: (a) data from the QA plan matrix (indicators, self-monitoring) were presented in 14 (100%), (b) the data presented were trended over time in 14 (100%), and (c) comments and interpretation/analysis of data were presented in 0 of the presentations (0%). n. Minutes from 8 of the 14 (57%) 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. These were since April 2014.	

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		In addition to QAD-SAC 1:1 meetings, QA reports, and QAQI Council, the monitoring team wishes to mention one other QA-related activity at LSSLC: • The unit directors, under direction of the residential director, were developing their own unit QA meetings and QA processes. They planned to utilize six or seven standard databases and add unit-specific topics, too. The residential director planned to do a quarterly presentation to QAQI Council. The monitoring team suggests that the unit level QA program be fully incorporated into the facility wide program, including periodic QAD-SAC 1:1 meetings. <u>Corrective Actions</u> The CAP system continued to develop. CAPs were mentioned in numerous meetings attended by the monitoring team and were being implemented across the facility. The QA department assigned a program compliance monitor the responsibility for managing the CAPs. To that end, she kept data on performance, periodically contacted responsible persons, and provided updates to QAQI Council at each meeting. The monitoring team reviewed a number of CAP-related documents (above in the Documents Reviewed list). There were 19 open CAPs. They were related to 8 Settlement Agreement provisions. The monitoring team reviewed 8 of the 19 open CAPs in detail. o. An adequate written description existed that indicated how CAPs were generated. p. When considering the sample of 8 CAPs, 8 (100%) CAPs were chosen following the written description, policy, or procedure. However, as also noted in section D4 of this report, when a negative pattern or trend was identified for specific individuals or at a systemic level, CAPs were not always developed. None of the investigations (section D) in the sample reviewed demonstrated that when a trend of similar incidents or injuries was identified, an adequate CAP plan was developed and outcomes were tracked. q. Of the 8 CAPs reviewed by the monitoring team, 8 (100%) appeared to appropriately address the specific problem for which they were created. • 6 of the 8 (75%) had measurable criteria (i.e., the newer CAPs). This was good to see. • 8 of the 8 (100%) CAPs looked at assessing outcomes to ensure that the problem originally identified was remedied or reduced. The QA PCM	

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		reported to QAQI Council on the status of the CAPs. At the QAQI Council meeting observed by the monitoring team, she verbally presented on 8 of the 19 open CAPs. Of these 8, she proposed 3 be closed (QAQI Council agreed), that 2 needed revision (one of which had been revised by the residential director), and that 3 had completed all of the action steps, but criterion had not been met and, therefore, these had to be revisited, revised, and likely, new action steps created, implemented, and evaluated. For example, all of the action steps to address skin integrity/decubitus were completed, but individuals continued to have occurrences of decubitus. ○ In one of the other CAPs, however, the QA department was tracking implementation of 85 action steps, but not whether these had impact on the outcome. With 85 action steps and a very broad CAP outcome, it was difficult to tell what is working and what was not. It might be better to have developed several smaller/easier to manage corrective action plans, with fewer action steps for each. Examples might include a single CAP to reduce the number of falls attributed to inappropriate clothing, or to reduce injuries due to peer to peer aggression in home X. Based on these 8 CAPs: r. 8 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. The CAPs contained a large number and wide variety of actions. The number ranged from 3 to 34. s. 8 (100%) included the anticipated outcome of each action step. • The QA PCM kept track of implementation of each action step. Most, however, did not have criterion for determining if the action step was implemented to the level desired by the writer of the CAP. Instead, the outcome was the rationale for implementing the action step. For some action steps, the criterion was somewhat self-evident (i.e., it was a yes/no implementation of a single action, such as to create a document or to train all staff), but many others would benefit from a criterion for determining completion. t. 8 of the 8 CAPs (100%) included the job title and name of the person(s) responsible. u. 8 of the 8 (100%) included the time frame in which each action step must occur (i.e., a due date).	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the 8 open/new CAPs, which represented 42% of the total: a. 8 (100%) included documentation about how the CAP was disseminated b. 8 (100%) included documentation of when each CAP was disseminated, and c. 8 (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 problems originally identified.	a. Based on a sample of 8 open CAPs and 0 closed CAPs, 8 (100%) were implemented fully and 8 (100%) were implemented in a timely manner. • The QA PCM kept a detailed spreadsheet that summarized the status of all CAPs and their action steps. There were columns that identified the number of action steps, the number implemented, the number that were implemented timely/late, the number not yet required to be implemented yet, and the specification of dates, responsible staff, etc. Overall, CAPs were addressed in a timely and full manner, even though some action steps were not implemented in a timely or full manner. It was good to see the facility self-identifying this. Late-implemented action steps were, for the most part, seen in the older CAPs. • The QAD included a monthly report of the status of the fully and timely implementation of the action steps in the CAP. b. There was an adequate system for tracking the status of CAPs. Of the 8 open CAPs being tracked by the facility, 8 (100%) indicated the status of the CAP. • The QA PCM assessed the status of every action step periodically (e.g., once per month). She kept a running commentary about status, actions, data, anticipated closure, etc. • The QA PCM kept two sets of comments: one regarding the facility's actions related to the CAP action steps, and one regarding her activities to verify implementation. This was a good method. 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. • The monitoring team recommends that the QAD trend/graph these data across months, and to include these data within her section E data inventory and QA report. d. The QA director or section leader did present this information to QAQI Council at	Substantial Compliance

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		least quarterly.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The monitoring team assessed metrics a. and c. The other metrics will be assessed at the next review because the QA department's system for managing modifications of CAPs was still developing. a. For 3 out of 8 CAPs (38%), documentation showed review of their effectiveness (i.e., outcomes), and for 8 out of 8 CAPs (100%), documentation showed review of their timely completion. b. Of the n.a. CAPs that appeared to need modification, n.a. (--%) were modified. c. Based on a sample of 0 completed CAPs and 8 in process CAPs, 5 (63%) were discussed at QAQI Council. 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. Further, as noted in section D4 of this report, it did appear that CAPs were implemented and tracked to completion. For most corrective action plans, there had not been enough time following implementation to determine if action was effective.	Noncompliance

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #004.2: 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 #344 and Individual #417 o A sample of ISPs for • Individual #402, Individual #470, Individual #170, Individual #418, Individual #526, Individual #551, Individual #410, Individual #60, and Individual #128. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Mike Ramsey, Incident Management Coordinator o Robin McKnight, Director of Behavioral Services o Stephani Sowell, Acting QIDP Coordinator o Gail Husband, ADOP o Stephen Webb, HRO <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 7/14/14 and 7/17/14 o ISP preparation meeting for Individual #116 and Individual #163 o Annual IDT Meeting for Individual #344 and Individual #417 o Castle Pine Unit Meeting 7/15/14 o Castle Pine LOS and Protective Device Review 7/15/14 o Morning Clinical Services Meeting 7/17/14 o Executive Safety Committee Meeting 7/17/14

	Facility Self-Assessment: LSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 6/24/14 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 the timely submission of assessments, ensuring that action plans were developed to address assessment recommendations, and the monitoring of supports and services..
	Summary of Monitor's Assessment During the last review, the QIDP Coordinator indicated that the facility had chosen to focus on improving attendance by team members identified as "required" at the annual ISP meeting and the submission of assessments identified as necessary prior to the annual meeting. Improvements were noted in both areas. These were good first step to ensuring that comprehensive ISPs were developed for each individual annually. Little progress was noted, however, with the development, monitoring, and revision of ISPs. The facility acknowledged that little progress had been made since the last review. This was in part attributed to turnover in the QIDP department, including resignation of the QIDP coordinator. Two annual ISP meetings were observed. Teams were not using preferences to build on new training opportunities for individuals. Preferences were typically based on a limited range of activities that the individual had the opportunity to participate in at the facility. Outcomes related to preferences were often general statements that ensured that the individual would have opportunities to continue to participate in those same activities with little discussion on how those preferences could be expanded or used to develop new skills. Observation at both day and residential programs confirmed that individuals were engaged in minimal meaningful activity throughout most of the day. The facility did not yet have an adequate process in place for monitoring supports and services. Thus, it was not evident that supports were consistently implemented and/or revised when needed. 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: 1. 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. 2. IDTs need to develop measurable outcomes and implementation strategies that will allow for

	consistent implementation and data collection. 3. 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. 4. 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.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings and two pre-ISP meetings. The ISP facilitator facilitated the annual IDT meetings. The QIDP was present at all meetings and co-facilitated the annual ISP meetings. 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 nine were submitted for review. Six of the nine plans were developed in January 2014, prior to the current review period. The acting QIDP director reported that little progress had been made in the ISP development process, thus, the sample was representative of the facility's current ISP process. The facility had 19 QIDPs. Three were designated ISP facilitators. One QIDP was new and not yet trained on meeting facilitation skills. The facility was not assessing QIDPs for competency in facilitation skills. 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 assessments and other information, the ISP	Noncompliance

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		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 #004.2 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 1/1/14 through 5/15/14. Participation had improved for attendance by the individual at his/her ISP meeting, however, attendance remained low for family/LAR participation. Additionally, participation remained poor for a number of disciplines, including the habilitation therapy staff, dietician, dental services, and primary care physician.	Noncompliance

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Team member	Attendance 8/1/13-10/30/13	Attendance 1/1/14-5/15/14
Individual	85%	65%
Family/Advocate/LAR	48%	47%
DSP	86%	85%
QIDP	100%	100%
Psychologist	72%	92%
RN	97%	98%
Occupational Therapist	59%	34%
Physical Therapist	60%	52%
Speech Therapist	36%	47%
Audiologist	0%	0%
Dietician	7%	26%
Primary Care Provider	46%	39%
Psychiatrist	68%	82%
Dental Services	11%	14%
Vocational Services	100%	87%
Active Treatment Staff/Day Program	100%	98%
Day Programming	-----	29%

Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified as relevant participants in eight of eight (100%) of the annual meetings in the sample. The sample included Individual #402, Individual #470, Individual #170, Individual #410, Individual #418, Individual #128, Individual #551, and Individual #526.

- At the annual ISP meeting for Individual #402, relevant team members identified at the pre-ISP meeting that did not attend the meeting included the individual, her family/LAR, PCP, and active treatment staff.
- At the annual ISP meeting for Individual #470, relevant team members identified at the pre-ISP meeting that did not attend the meeting included the individual, her family/LAR, DSP, SLP, and active treatment staff.
- Key team members not in attendance at Individual #170's annual ISP meeting included the individual, his LAR, DSP, dietician, and active treatment staff.
- Key team members not in attendance at Individual #410's annual ISP meeting included the individual, his LAR, LA, and active treatment staff.
- At the annual ISP meeting for Individual #418, relevant team members identified at the pre-ISP meeting that did not attend the meeting included his family, home manager, and active treatment staff.
- Individual #526's family did not attend the meeting in person or by phone.
- Individual #128's speech therapist and home manager did not attend her annual ISP meeting.

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Individual #551 did not attend her annual ISP meeting. Day programming staff were also not in attendance at the meeting.
Documentation of psychiatric attendance at IDT, ISP, and PBSP meetings was reviewed. Between 1/3/14 and 5/19/14, there were a total of 55 ISP meetings with documentation indicating that psychiatry was present at 45 meetings (81%). This was a reduction from a total of 110 ISP meetings reported in the previous monitoring report. Documentation indicated that for the 10 meetings that psychiatry did not attend, psychiatry clinic staff attended in their stead. Furthermore, documentation indicated that when the physician did not attend, it was because they were not present at the facility on the day of the meeting. 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.

The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process.
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<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 #004.2 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 continued to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Responsibility for gathering data regarding submission of clinical assessments prior to the annual ISP meeting had moved from the QIDP department to the QA department. The chart below shows timely assessment submission rates for February 2014 through June 2014.
<table>
<tr><td>Discipline</td><td colspan="5">Submitted on time
(at least 10 days prior to annual IDT meeting)</td></tr>
<tr><td></td><td>Feb 2014</td><td>Mar 2014</td><td>April 2014</td><td>May 2014</td><td>June 2014</td></tr>
<tr><td>Medical</td><td>85%</td><td>78%</td><td>100%</td><td>100%</td><td>97%</td></tr>
<tr><td>Psychiatric</td><td>64%</td><td>93%</td><td>53%</td><td>100%</td><td>100%</td></tr>
<tr><td>Nursing</td><td>100%</td><td>93%</td><td>96%</td><td>96%</td><td>94%</td></tr>
<tr><td>Dental</td><td>89%</td><td>89%</td><td>89%</td><td>96%</td><td>97%</td></tr>
<tr><td>QDRR</td><td>78%</td><td>100%</td><td>93%</td><td>63%</td><td>82%</td></tr>
<tr><td>Psychological</td><td>74%</td><td>85%</td><td>82%</td><td>96%</td><td>94%</td></tr>
<tr><td>Hab. Therapies</td><td>96%</td><td>92%</td><td>96%</td><td>95%</td><td>100%</td></tr>
<tr><td>Communication</td><td>9%</td><td>17%</td><td>73%</td><td>80%</td><td>78%</td></tr>
<tr><td>Nutrition</td><td>74%</td><td>96%</td><td>82%</td><td>100%</td><td>88%</td></tr>
<tr><td>Functional Skills</td><td>100%</td><td>85%</td><td>56%</td><td>61%</td><td>No data</td></tr>
<tr><td>PSI</td><td>100%</td><td>85%</td><td>56%</td><td>61%</td><td>No data</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	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 #402, Individual #470, Individual #170, Individual #410, Individual #418, Individual #128, Individual #551, Individual #60, and Individual #526. Zero (0%) of nine 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 from that review.	

Individual	Recommended assessments not submitted	Recommended assessments submitted late
#60	n/a	Speech
#418	n/a	Pharmacy
#526	n/a	Audiology
#128		Medical, Nursing, Communication, Psychiatry
#410	n/a	Functional Assessment
#170	n/a	Communication, Audiological, Nutrition
#551	Psychological	N/a
#402	n/a	Communication
#470	Communication	Pharmacy, Dental, Behavioral

The timeliness of some assessments had improved. For example, the timeliness, as well as, the quality of functional assessment, full psychological assessments and annual psychological updates was excellent as noted in K5 and K7. Vocational assessments were also timely.

All habilitation therapy assessments reviewed included a description of the individual's strengths and preferences, however, there were many individuals who did not have a current communication assessment. The therapists only occasionally provided a suggestion for a SAP, and there was no evidence that they participated in the development, training, or review of these. The clinicians made recommendations for direct therapy in some cases. Measurable and functional objectives were typically outlined for OT and/or PT services. This was not always the case for speech therapy, but rather these were more general statements of outcomes, such as the individual will progress in the use of AAC.

The facility had continued to track IRRF submissions for psychiatry assessments. Between 2/10/14 and 7/10/14, 72 IRRF documents were prepared and submitted. Of these, 15 (20%) were delinquent. This was an improvement over the previous

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		monitoring period where 61% of the submissions were delinquent. It is imperative that psychiatry is an active part of the ISP process inclusive of the timely submission of IRRF and attending the ISP meetings. The majority of the nursing assessments reviewed did identify the individual's strengths, preferences and needs. Even so, most did not incorporated health. For example, Individual #134 was determined high risk for infections. The individual's strengths included being independent in eating, dressing and undressing, and responding to simple instructions. Strengths did not identify if he was able to participate in his own health care, such as for handwashing to reduce risk transmission of infections. 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. 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, although based on submission rates for functional skills assessments and preference and strength inventories (PSIs) prior to the annual meeting, it was questionable whether or not these lists were accurate. 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 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 ensuring that assessments were submitted prior to the ISP meeting. 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. In some cases, improvements were noted in the use of assessment recommendations to develop supports. For example, recommendations from assessments were consistently used to develop PBSPs for individuals. On the other hand, as identified in S2, only 53% of	Noncompliance

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		SAPs reviewed were based on clear needs identified in assessments. In over half of the reviewed assessments, the recommendations section did not include recommendation to adequately guide IDT to support the individual and develop a plan of care to help the individual address a health or behavioral issue. For example, Individual #556 had one-to-one supervision to keep him from pulling out his gastrostomy tube. Recommendations did not include assessing for any underlying reasons to address if a cause may be discomfort due to placement or positioning. Most recent nursing assessments reviewed did not contain statements that were used to develop appropriate protections, services, and/or supports for the individual. For example, the assessment for Individual #235, who had an artificial airway (tracheostomy), did not contain substantive statements to develop protections and supports related to her artificial airway (tracheostomy). Habilitation therapy recommendations typically focused on the development of the PNMP to address health and risk concerns, with less attention to the development of functional skill acquisition. This was noted more often in the case for speech, though many individuals, as noted, did not have current communication assessments. At the two ISP meetings observed, assessment recommendations were included in the draft ISP, the IDTs reviewed the information by having each discipline read information entered into the draft form. The ISP facilitator reviewed each individual's preferences and strengths. Neither team developed outcomes or new training opportunities based on assessment recommendations. For example, Individual #417's preferences included community excursions and getting her nails polished. The team agreed that she needed to remain active during the day and needed additional exposure to the community. One team member suggested that having her nails done in the community might be a good training objective. Another team member reported that she had her nails manicured at the facility and probably preferred this. The team missed an opportunity to provide a new training opportunity in the community based on her preferences. The team developed a general outcome for her to attend the day program Monday through Friday. Specific training outcomes based on her needs and/or preferences were not developed. Individual #344's IDT also developed general outcomes for community excursions and attendance at the day program without considering outcomes based on assessed needs and/or preferences. 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 then recommendations from assessments are used to develop and revise supports as needed.	

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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 to the community. Assessment templates had been revised to include a living determination statement. Assessment completed in the past six months included this statement. Examples of assessments that did not include this statement were: • Individual #418's medical and nursing assessments did not include a recommendation/determination; • Individual #470's nursing and OT/PT assessment did not include a recommendation statement regarding referral to the community; • Individual #170's medical and nursing assessments did not include a recommendation statement regarding referral to the community. 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 IDT determinations. Eight ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #402, Individual #470, Individual #170, Individual #410, Individual #128, Individual #551, Individual #60, and Individual #526. Only one of the individuals in the sample was offered a range of opportunities to participate in meaningful activities in the community. Individual #60 had outcomes for further exposure to the community based on her preferences that could reasonably expand her integration into the community. This included going shopping, going to get manicures and pedicures in the community, and going to the wig store to choose a wig. Community based outcomes for most individuals in the sample consisted of generic opportunities to visit in the community with little or no opportunity for measurable training or meaningful integration. For example: • For Individual #470, the IDT had included the community as an option for some of her outcomes. Most outcomes were just opportunities to continue doing what	Noncompliance

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		she enjoyed, rather than outcomes to provide meaningful training. For instance, she had an outcome to listen to her preferred music with headphones for 10 minutes. The community was marked as a possible training site. Other outcomes included providing opportunities to attend off campus activities, opportunities to go on community outings, and opportunities to participate in activities that she enjoyed. None of these included specific training opportunities or even guidance based on her support needs or preferences. • Similarly, Individual #402's community based outcomes were to "participate in community outings" and "staff will continue to assist to attend as many social activities on campus and off campus as possible." Outcomes that indicated training could be provided in the community stated "will be provided informal training in money management," will be provided with opportunities for independence according to her abilities," and "will access her pressure switch while requesting assistance." Again, outcomes were not written in a way that staff would know what specific training should occur, how progress would be measured, or what supports were needed. None (0%) of the individuals in the sample had adequate access to the use of community services and community supports (e.g., hair salons, gyms, banks, churches, pharmacies). None (0%) of the ISPs in the sample indicated that the individual was adequately integrated into the community (regularly participated in activities in the community and engaged with others in the community, had memberships, hobbies, and interests, works/volunteers, or contributed to the community in some way). The facility provided limited day programming opportunities in the community. ISPs included minimal formal training to be implemented in the community. General outcomes were written to attend activities at community sites without describing what training would occur while there. At both IDT meetings observed (Individual #417 and Individual #344), the IDT engaged in discussion regarding community living options. The IDTs developed outcomes for further exposure to living options through attendance at provider fairs and visits to community group homes, however, the IDT did not consider other outcomes that would encourage community integration for further exposure to new things 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. There was no focus on providing supported employment or volunteer opportunities in	

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		the community for individuals at the facility. None (0%) 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, identifies the supports that are needed, and encourages community participation;	In order to meet substantial compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. It will be necessary for all assessments to be completed prior to the annual ISP meeting to ensure the team will have information necessary to determine prioritized needs, preferences, strengths, and barriers. In the ISP meetings observed, IDTs engaged in a discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting and attempted to develop plans to include the individual's preferences. Teams were not adept at using preferences to build on new training opportunities for individuals. Preferences were typically based on a limited range of activities that the individual had the opportunity to participate in at the facility. Outcomes related to preferences were often general statements that ensured that the individual would have opportunities to continue to participate in those same activities with little discussion on how those preferences could be expanded or used to develop new skills. All eight (100%) ISPs in the sample included a listing of individual's preferences and strengths. Most were related to experiences offered at the facility. None of the individuals' teams (0%) had effectively incorporated their preferences into related action plans. Often, teams used preferences as a continuation of what the individual already was doing (e.g., outings into the community or visits with family), as opposed to as a way to expand the individual's opportunities. ISPs in the sample	Noncompliance

#	Provision	Assessment of Status	Compliance
		provided few opportunities to gain exposure to new activities and learn new skills. In terms of healthcare needs, a majority of the records reviewed appropriate supports regarding constipation, were not developed, and most of the plans (ACPs/IHCPs) did not contain individualized measurable goals/objectives based on the individuals identified needs. For example, Individual #556's record stated that he had a bowel management plan, which consisted of, if no BM in three days, he was to receive an enema. There were measurable goals established for direct therapies across OT, PT, and speech, but these were typically not included in the ISP. 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 eight ISPs, one (12%) 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 to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in	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 four ISPs in the sample that were developed after the last monitoring visit were reviewed (Individual #402, Individual #470, Individual #170, and Individual #90). 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 #402 had an outcome to "interact with others to receive attention as	Noncompliance

#	Provision	Assessment of Status	Compliance
	the most integrated setting appropriate to his/her needs;	well as participate in various activities." Action steps to achieve this outcome did not help to clarify how the outcome would be implemented or what staff would measure. For example, one of the action steps stated that he would "participate in outdoor activities, wheelchair walks, and community outings." There were no staff instructions to indicate what supports would be needed, how often he would engage in each activity, or what level of participation was required. His outcome to increase independent living skills, had an action step that stated "will be provided informal training in money management." Again, there were no staff instructions to define what staff support was needed or what would be measured. • Individual #470 had an outcome "to be provided with activities and training at 550 or on her home." Action steps included, "will attend formal training activities at 550 or simulated training on her home." The ISP did not specify what type of training would occur, what skills would be addressed, what would be measured, or even how staff were to determine at which site training would occur. Another action step in her ISP stated "will assist in her daily needs according to her abilities." There were no staff instructions to identify what her daily needs were, what supports were needed, or what training would occur and how it would be measured. She did not have an IHCP with measurable outcomes to address her risks. • Individual #170's ISP was a better example of an ISP that included individualized, measurable objectives based on needs and preferences identified through the assessment process. His ISP, however, still included some outcomes and action steps that were not written in a way that staff could consistently implement them and measure progress. For example, he had an action step to state how much money he needs to ride the train. There were staff instructions on implementation to ensure that staff knew what prompts to provide, what his destination would be, and information regarding the amount of a ticket. Another action step stated that he would wake up earlier each morning and participate in activities in order to revise his sleeping schedule. There were no instructions to direct staff in how to wake him or what time would be considered a successful attempt. • Individual #90 only had one action step related to day training. It was a general goal to attend class once per week. There was no information given on what type of training would occur while in class. She had a general IHCP outcome to address her risk for aspiration that referred staff to her PNMP. Another outcome stated "regular dental visits on the home and the dental office on campus." The plan did not include what supports were needed to ensure visit were completed or how often the action should be implemented.	

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		Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. The monitoring team found that individualized measurable treatment strategies based on identified needs were developed, in some cases. Examples included functional assessments and PBSPs. Assessments were not consistently used, however, to develop SAPs. 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. The facility had not made progress in developing measurable, meaningful objectives for individuals at the facility. It was noted during observations, that individuals were still not engaged in meaningful training throughout most of the day. ISPs will need to include clear outcomes and action step that direct staff designated to implement training.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The ISP template included prompts to ensure that the IDT discussed all supports provided by the facility. The 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. Inclusion in the ISP, however, did not ensure that services and supports were integrated throughout the individual's day. As noted in F2a2, outcomes rarely included a description of supports needed for consistent implementation. The development of action plans that integrated all services and supports was still an area that the facility needed additional training on. Assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members, so that information could be integrated among disciplines. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings. The 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 reviewing supports provided the previous year, but there was still little discussion among team	Noncompliance

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		members regarding how to integrate recommendations with information regarding preferences and daily schedules.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Method for implementation</u> As discussed in F2a2, action steps in the sample of ISPs reviewed often did not include clear methodology for implementation. 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. 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. <u>Time frame for completion</u> A sample of ISPs were reviewed to verify that outcomes included a time frame for completion. In all cases (100%) where a date was given, 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. For IHCP's in the sample, the completion date was listed as "ongoing" for each outcome. Even when the IHCP called for specific appointments or assessments (e.g., annual dental exam, lab work), the team failed to assign an appropriate completion date. <u>Staff responsible</u> 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 increasing independence in routine household activities, such as laundry, yard work, and	Noncompliance

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		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 skills were rarely adequately addressed. When vocational outcomes were developed, they were often 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. Observations at the facility supported that most individuals had very little structure in their day. During observation at the day programs, minimal engagement in meaningful activities was observed by the monitoring team. During the review week, two of the day programs on campus were closed due to the rain. Individual stayed at home the entire day, even though the rain was sporadic throughout most of the day. 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. IDTs often did not identify specific support needs that were barriers to living in the community. Broad terms such as "limited exposure to the community" and "significant behavioral or health needs" were identified as barriers to moving. The IDT then developed broad goals for "greater community exposure" or "stable health/behavior" without considering specific outcomes that would move the individual towards greater independence. To move forward, IDTs will need to accurately identify 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	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 although location of documentation was specified rather than type of documentation. 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.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>data review.</td><td>IDTs will need to develop outcomes that are measurable in order to permit objective analysis of the individual's progress.</td><td></td></tr>
<tr><td>F2b</td><td>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.</td><td>This provision item will require that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services. Please refer to these sections of the report regarding the coordination of services as well as G1 regarding the coordination and integration of clinical services.

As noted in F1, adequate assessments were not always 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. When completed after the annual IDT meeting, the QIDP needs to ensure that assessment information is integrated into the ISP including the SAPs.</td><td>Noncompliance</td></tr>
<tr><td>F2c</td><td>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.</td><td>A small sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in all (100%) of records reviewed. Data reviewed for ISP submission between 1/1/14 and 5/14/14 indicated that 118 of 121 (98%) of the ISPs developed within that timeframe were filed in the active record within 30 days of development. This was a significant improvement from that last review when it was reported that only 51% of the ISPs were filed within 30 days.

<table><tr><th>Month</th><th>Number of ISPs filed within 30 days of development</th><th>Percentage of ISPs filed within 30 days</th></tr><tr><td>January 2014</td><td>28/31</td><td>90%</td></tr><tr><td>February 2014</td><td>27/27</td><td>100%</td></tr><tr><td>March 2014</td><td>25/25</td><td>100%</td></tr><tr><td>April 2014</td><td>27/27</td><td>100%</td></tr><tr><td>May 2014</td><td>11/11</td><td>100%</td></tr></table>
As noted in other sections of this report, the monitoring team found that outcomes were rarely written in measurable terms, so that those monitoring the plan could determine when progress was made or if the outcome was completed. Additionally, teaching and support strategies were not comprehensive enough to ensure that staff knew how to implement the outcome and provide appropriate supports based on assessment recommendations.</td><td>Noncompliance</td></tr>
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		DSPs interviewed during the review were 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.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	QIDPs were assigned overall responsibility for monitoring services and supports in the ISP. The facility had a monthly review process in place to review all supports. The monthly review form had been revised in January 2014 with prompts added to review specific supports and services and graphs to show progress or lack of progress. The QIDPs were doing a much better job of including specific data relevant to progress and reviewing a wider range of supports. The revisions to the monthly review documentation included moving from a separate monthly review each month to a cumulative form that reviewed the individual's status through the ISP year. Based on a sample of monthly reviews that had been completed using the new format, it was easier to determine when progress or regression was occurring. It was also easier to identify issues that needed follow-up by the QIDP such as missed appointments, implementation of recommendations by consultants, and trends of illness or injury. A review of QIDP monthly reviews, however, indicated that rarely did the monthly review adequately reflect the status of all outcomes and services included in the ISP. For example, • Individual #90 did not have monthly reviews completed for March 2014 through June 2014. • Individual #402's monthly reviews for March 2014 and April 2014 did not document a review of actions steps in her IHCP to address her risks. • Individual #526's QIDP monthly reviews did not document review of his IHCP	Noncompliance

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		outcomes for the months of February 2014 through April 2014. • Individual #418's ISP indicated that the SLP would be assessed for a voice output device. The QIDP noted that he continued to receive speech services, however, there was no mention of whether or not the assessment for the voice output device had been completed. Additionally, there was no documentation of review of his IHCP from January 2014 through March 2014. His neurologist recommended a follow-up appointment for February 2014. The QIDP monthly review noted that the consultation was not documented, however, there was no documentation regarding follow-up to assure that the consultation had been obtained. Status of the consultation was not reviewed in the March 2014 and April 2014 monthly reviews. A sample of QIDP monthly reviews were reviewed to determine if the IDT convened as needed when there was a change in the individual's status or support needs, evidence that the ISP was not being implemented, or a lack of progress towards outcomes that might require revision of the ISP. The monitoring team found that the monthly review process was not always adequate for ensuring that ISPs were modified, when appropriate. For example, • Individual #402's QIDP monthly reviews indicated that her outcome to attend social activities on or off campus was not implemented in March 2014 or April 2014. The March note stated "did not attend any social activities" and the April note stated "none reported this month." There was no explanation for the lack of implementation and no documented follow-up by the QIDP. • Individual #90 had nine falls documented in May 2014. The IDT did not meet until 6/20/14 to review her falls and at that time made a referral to the PNMT. An assessment was never completed and the IDT failed to follow-up on the referral. • Individual #551's QIDP monthly review indicated that her outcome to participate in communication training was not implemented from January 2014 through April 2014. There was no explanation for the lack of implementation and no documented follow-up by the QIDP. Her team had recommended an OT assessment in January 2014. The QIDP noted in April 2014 that the assessment had not been completed. There was no documentation of follow-up by the QIDP. • Individual #526's ISP included an outcome to "consider" revising his positive behavior support plan to increase emphasis on work attendance and participation. The QIDP monthly reviews for February and March 2014 noted that he refused to go to work numerous times. There was no documentation of IDT discussion regarding modifying his PBSP or any other action taken to address his work refusals. • Individual #170's IRRF dated 2/3/14 indicated that he had outstanding referrals	

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		for an EKG, bone density scan and consultation with the dietician due to elevated lipid panels. His QIDP monthly reviews for February 2014 through May 2014 indicated no pending assessments. There was no documentation to show the assessments were completed or reviewed by the team if completed. The monitoring team found little evidence that individual team members were following up on their responsibility to monitor services and supports and document specific progress or regression. Additionally, supports were not always modified when the individual experienced a change of status, regression occurred, and/or outcomes were not achieved. Nursing services and supports were not consistently monitored, and specific progress or regression was documented to include when the individual had a change in skin integrity. For example, Individual #556 was not consistently monitored for his risk of skin integrity, even though the IDT had met and determined to raise his risk from low to medium. Direct therapy was reviewed after each session with data and IPNs recorded. Monitoring for compliance and effectiveness of the PNMP and communication supports was not routinely conducted for the samples reviewed (i.e., less than quarterly in most cases). There was some evidence of modifications to treatment plans when progress was not consistent. However, it did not appear that PNMPs were adequately and routinely reviewed to ensure this. The monitoring of behavioral services and supports had improved. For example, monthly PBSP progress notes were completed and indicated that action occurred when the individual outcomes were not achieved. The monitoring team found that the current IDT process is not adequate for implementing, assessing, and monitoring of services for individuals. To move forward towards compliance, 1. QIDPs should complete a comprehensive review of all services and supports at least monthly. 2. 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. 3. Plans should be updated and modified as individuals gain skills or experience regression in any area.	

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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 received additional training by the state office on developing and implementing the ISP. QIDPs were still learning to use the ISP format to develop the ISP. The facility did not have a process in place for assessing QIDP competency regarding ISP development. 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. See comments regarding the monthly review process in F2d. To move forward, the facility will need to 1. Implement a process for assessing the competency of QIDPs in facilitation skills and ISP development. 2. Ensure that 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 thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current ISPs were available all records reviewed. The monitoring team requested a list of ISP dates with the date the ISP was due, the date the meeting was held, and the date the ISP was filed (document V.10). Data provided by the facility for January 2014 – May 2014 indicated that while all ISP meetings were held within 365 days of the previous ISP meeting, 89% of the ISPs were filed within 30 days of development. The data indicated a significant improvement in timeliness of ISP submission. 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.	Noncompliance

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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: • Section F audits were conducted. • 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 continued 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 was still in the development phase.	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 Operational Procedure Process for On-Campus/Off- Campus Consultations and Treatment Procedures, 12/15/13. 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 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 included the participation of staff in ISPs and committee meetings, results of the Quality Services Review and review of

	documentation of the clinical meetings. For provision G2, the facility reported audit data based on the state G2 audit tool. The metrics used appeared to be reasonable. Future self-assessments should include similar items. Additional metrics may be added based on the finalization of a state policy for this provision. The facility found itself in noncompliance with both provision items. The monitoring concurred with the facility's rating.
	Summary of Monitor's Assessment: The facility made some progress in this area. The Quality Services Review process, which was developed to measure integration of services, was finalized. Eight audits were conducted and feedback was provided to the teams. A number of processes showed improvement with regards to integration of services, including the suction toothbrushing program, skin management, dental desensitization, and the oversight of psychotropic polypharmacy. The daily medical meetings were expanded to include more discussion of clinical issues. There was evidence that integration was occurring. However, there were several areas that needed substantial improvement. Physician participation in annual ISPs and the Medication Variance Committee meetings remained poor. There was improvement in the use of IPN template for consultation documentation. The content of many notes, however, was problematic. The notes were increasingly becoming a copy of the consult text. The content of the note was intended to be a summary explaining the significance of the consultation findings. Moreover, the providers were not referring the recommendations to the team even when it was clearly beneficial to do so.

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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. LSSLC finalized the process for measuring integration of clinical services – the Quality Services Review of ISP and Integration of Services. This process 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, habilitation, human rights, nursing, psychiatry, and active treatment (QIDP). Each discipline completed the	Noncompliance

#	Provision	Assessment of Status	Compliance
		audit tools. Feedback was then provided to the disciplines and IDT of the individual under review regarding the quality of the integrated services. Two reviews were completed each month and eight reviews were completed at the time of the compliance review. 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. The monitoring team observed a number of meetings throughout the week of the compliance review including: • Daily Medical Meeting • Pneumonia Review Committee • Skin Integrity Committee • Medication Variance Committee • Pretreatment Sedation Committee • Polypharmacy Committee The clinical disciplines demonstrated efforts to develop plans, actions, and strategies to increase the quality of integrated services. Specific findings regarding these meetings are discussed throughout this report. A number of clinics, activities and processes that were observed or discussed demonstrated integration of clinical services: • The dental, nursing, and habilitation departments worked collaboratively to ensure that individuals received suction toothbrushing treatment. • The dental clinic and the behavioral health services department worked together to address barriers to dental care such as refusal of treatment. • The habilitation therapists worked collaboratively to complete Comprehensive Assessments and Assessment of Current Status on annual basis as well as in the interval assessments for acute concerns and change in status. • The PNMT members worked together to assess and provide PNM supports to individuals and the IDTs. There was some evidence of collaboration with behavioral health services to address communication needs for individuals as they related to behavior, though this needs to improve. • Members of the IDT, including behavioral health services, nursing, pharmacy, and habilitation services, were generally present when quarterly psychiatry clinic and other psychiatric clinical consultations occurred. • Behavioral health services demonstrated functional integrated services with psychiatry.	

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		Several areas offered great opportunities for improvement: • Although physician participation in the annual ISPs increased, additional work was needed in this area to improve integration of medical services. • There was little evidence of medical participation in the medication variance program. Documentation of meeting minutes indicated that only one meeting since the last compliance review included participation by a physician. • Improvement was needed and integration between psychiatry and neurology. • There was evidence dental and behavioral health services were working collaboratively to address refusals, however, those efforts needed to be expedited. The self-assessment completed for section G just prior to the onsite review documented that plans to address refusals were "soon to be in place." While the behavioral services director and dental director described the process, there was little documentation at the time of the compliance review that this had actually occurred for a number of individuals who needed assessment by behavioral health services. • The pneumonia review committee lacked pharmacy input. Knowledge of the medication profiles of the individual is important in the management of pneumonia. Overall, the monitoring team found progress in this area. The facility had demonstrated that the clinical disciplines had the capacity to work collaboratively to address several issues and deliver services in an integrated manner. Improvement is needed in the area of integration as well as the disciplines' ability to self-identify the problematic areas. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating of noncompliance. In order to move towards substantial compliance the facility should address the concerns cited above.	
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	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	Noncompliance

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	supports and services.	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 January 2014 were reviewed: • 36 of 50 (72%) consultations met the documentation requirements to summarize the consult, agree or disagree, and comment on the need to refer to the IDT. There was improvement noted in this area. There was more consistent documentation in the IPNs by the providers. Even so, there were two findings of concern. The first was the majority of the IPNs had the content of the consults copied verbatim, including all technical jargon. State policy specifically required that the IPN documentation summarize and explain the significance of the results. In order to do this, the primary provider must document a reasonable summary and interpretation of the consult recommendations. It has been reported that the medical LVNs assisted providers by entering information into the template. This was likely the reason that the consults were being copied into the template. At times, this appeared reasonable. In some cases, however, copying unedited technical jargon was not helpful in understanding the significance of the consultant's findings. The second concern was the issue of IDT referral. The primary providers did not refer matters to the IDT that should have been. It appeared that staff interpreted IDT referral as the need to obtain IDT approval for implementation of recommendations. There are matters that should be discussed with the IDT prior to implementation. The intent of the requirement is for the IDT to have knowledge of recommendations that impact the existing supports. Thus, the IDT should be informed of changes in psychotropics and AEDs because of the ability to impact seizure frequency and behavior. It should be also clear that the IDT needs to be informed of upcoming procedures and diagnostics so that the necessary supports can be implemented. Compliance Rating and Recommendations The monitoring team agreed with the facility's self-rating of non-compliance. To move in the direction of substantial compliance, the providers must review and document consults in accordance with state guidelines. Primary providers should provide a summary of the consultation rather than copy the consultant's note.	

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 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. Future self-assessments should include data related to interval assessments. This will require that audit tools have metrics that are specific and measurable.

	The facility found itself in noncompliance with provision H1, H3, H4, H5, H6 and H7. The facility rated itself in substantial compliance with provision H2. The monitoring team agreed with this self-assessment.
	Summary of Monitor's Assessment: During the week of the onsite visit, the monitoring team had the opportunity to meet with the facility director and QA nurse who served as the lead for this provision item. Progress was made in provision H1. The facility had addressed the timeliness of annual and quarterly assessments. Clinical disciplines had also developed tools to address the quality of annual assessments. Most disciplines had also developed tools to determine the quality of quarterly assessments. There were no systems in place to track interval/unscheduled assessments by the clinical disciplines. Overall, for psychiatry services, the diagnostic formulation documentation was appropriate. The medical providers generally utilized ICD nomenclature and the diagnoses were consistent with the signs and symptoms of illness. The facility continued to focus its efforts on provisions H1 and H2. The facility had a local policy for addressing this provision. It covered 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 individual's status to ensure the timely detection of individuals' needs.	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. LSSLC developed a local policy to guide the work for provisions G and H. The policy described the facility's approach to management of assessments in addition to providing guidance for the other provision items of section H. 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. 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	Noncompliance

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		received after the 10th day prior to the ISP were considered delinquent. Each of the clinical disciplines had an internal system to track the timeliness of completion of annual assessments. The facility maintained a centralized tracking system. The following data for compliance with timely submission were submitted.	

Annual Assessment Compliance Data 2014 (%)

	Jan	Feb	Mar	Apr	May	June
Dental	100	89	89	89	96	94
Dietary	76	74	96	82	100	100
Hab: OT/PT/SPL	89	96	92	96	95	100
Hab: CSK	30	9	17	73	80	78
Hab/Audiology	92	77	45	88	100	93
Medical	86	85	78	100	100	97
Nursing	93	100	93	96	96	94
BHS	86	74	85	82	96	94
Psychiatry	53	64	93	53	100	100
QDRR	97	78	100	93	63	82
Overall Rate	80	75	79	85	93	92

Clinical disciplines were required to develop a corrective action plan for compliance rates <85%. In order for the action plan to be closed, a compliance rate of 85% or greater was needed for two consecutive months along with the approval of the QA/QI Committee. The facility's Quality Service Review also assessed the compliance with timely completion of comprehensive evaluations and assessments.

The quality of annual assessments was audited by medical, psychiatry, nursing, dental, pharmacy, behavioral health services, dietary, and PT/OT/ST. Audiology had not developed a quality audit tool.

The timeliness of quarterly assessments was tracked by medical, nursing, pharmacy and psychiatry. Data from the centralized tracking system is presented in the table below.

Quarterly Assessment Compliance Data 2014 (%)

	Mar	Apr	May
Medical	100	100	100
Nursing	100	100	100
Pharmacy	82	35	96
BHS	61	84	98
Psychiatry	89	64	70
Overall Rate	86	77	93

All clinical disciplines, with the exception of medical, had systems in place to track the quality of quarterly assessments. The facility did not address the requirement to

#	Provision	Assessment of Status	Compliance
		complete interval assessments. Thus, the self-assessment included no data related to this requirement. The monitoring team reviewed the full spectrum of assessments including annual assessments, quarterly assessments, and interval assessments. The monitoring team noted the following with regards to the evaluations of the facility's various assessments: • For the facility submitted sample, the compliance for timely completion of Annual Medical Assessments was 73%. The quality of medical assessments is discussed in detail in section L1. • Quarterly Medical Assessments were found in most records included in the record sample. It appeared that one provider was not completing these assessments. The quality of the assessments is discussed in section L1. • The completion of Quarterly Drug Regimen Reviews improved since the last compliance review. Compliance for the reporting period was 73%. This was an improvement from the compliance score of 45% noted for the last compliance review. However, the quality and clinical relevance of the QDRRs will need to be addressed. • Compliance with timely completion of Annual Dental Assessments was 85% for the reporting period. Additional details on dental assessments can be found in section Q1. • OT, PT, and SLPs conducted annual assessments for individuals with identified needs. Interval assessments were completed as indicated for changes in status. These served to determine if changes in the PNMP or other supports were needed. The PNMT nurse also conducted post-hospitalization assessments for individuals hospitalized with a PNM-related issue. • For the 12 records included in the record sample, seven included a completed Admission/Annual Comprehensive Nursing Assessment. The majority was completed in accordance with the individuals' ISP dates. The nursing assessments for most records did not consistently qualify or quantify the responses to interventions such as medications and treatments. • Facility submitted data from January 2014 through June 2014 indicated that 100% of individuals requiring quarterly psychiatric clinics were seen in clinic. It was noted that while these occurred during the quarter, there was a percentage of assessments that were documented as "on time." It was noted that this indicated the final assessment, including documentation, was completed within 10 business days of the assessment date. For the reporting period, on average, 80% of assessments were completed "on time." Per the monitoring teams review of the data provided, five quarterly psychiatric clinic reviews were outdated, with four individuals last seen in February 2014 and one in January 2014. As such, 2% of the individuals participating in psychiatry clinic were	

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		delinquent with regard to quarterly psychiatry clinic follow up. • The facility had continued to track IRRF submissions. Between 2/10/14 and 7/10/14, 72 IRRF documents were prepared and submitted. Of these, 15 (20%) were delinquent. This was an improvement over the previous monitoring period where 61% of the submissions were delinquent. It is imperative that psychiatry is an active part of the ISP process inclusive of the timely submission of IRRF and attending the ISP meetings. • Functional assessments were completed and timely for 94% of individuals with PBSPs. Similarly, 98% of individuals at LSSLC had a full psychological assessment, and 99% of individuals had an annual psychological update. • While 91% of vocational assessments were available to team members at least 10 days prior to the ISP, only 80% of FSAs and 78% of PSIs were available. <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 Classification of Diseases and Related Health Problems.	The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the IPN documentation revealed that the medical diagnoses were consistent with ICD nomenclature. The diagnoses, for the most part, fit the signs and symptoms documented. The APLs were not always appropriately updated with current data, 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 documentation of specific criteria exhibited by an individual indicating a particular diagnosis. There were challenges as data points collected did not routinely correspond with diagnoses or target symptoms identified for treatment with a particular psychotropic medication. Admittedly, this had improved over the course of monitoring. <u>Compliance Rating and Recommendations</u> This provision item remains in substantial compliance.	Substantial Compliance

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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.	To assess compliance for this provision, the facility reviewed a number of areas: • The nursing department reviewed a 15% sample of records using the acute injury/illness audit tool. • Thirty audits were conducted for individuals with skin problems. The documentation of improvement using current interventions was assessed. • Nursing SOAP documentation was audited to determine if (1) the analysis of the problem was correct, (2) documentation reflected appropriate nursing interventions and (3) there was a plan for follow-up of problems. • The medical department audited Annual Medical Assessments. Question #20 addressed the presence of a plan for all active problems. • The psychiatry department used a polypharmacy auditing process that reviewed the psychiatrist's documentation to ensure that adequate justification for the treatments used was documented. • Behavioral health services audited a sample of assessments. To determine if treatments based on the assessments was appropriate, the audit tool included a question to determine if interventions matched the functional assessment. The section H state draft guidelines indicated that facility staff would utilize the clinical pathways, guidelines, and protocols to govern treatments and interventions as appropriate. Additionally, the draft guidelines stated that the facility was responsible for providing education and development of the clinical staff with regards to the guidelines and protocols. <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 monitor a full range of treatments and interventions. Indicators should be developed based on the state protocols and other common medical conditions. The facility will need to develop protocols and monitor those conditions determined to have the greatest impact on health status. Conditions that affect many individuals or those that have presented medical management challenges should be considered. Medical audits, hospital and emergency department data as well as the sick call roster have the potential to provide insight on how prioritization should occur.	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	In order to assess compliance with this provision item, the facility reported data on the internal and external medical management audits. The conditions audited were diabetes, osteoporosis, and pneumonia. Additional information on this process can be found in section L2 and section L3.	Noncompliance

#	Provision	Assessment of Status	Compliance
	a clinically justified manner.	The proposed section H guidelines stated that the facility would ensure that targeted clinical indicators measure the response to treatment and interventions and data would be monitored to determine the appropriateness of the interventions. The actions steps to achieve this centered on development of clinical indicators by the clinical disciplines for seven acute and chronic health care conditions. LSSLC had developed clinical indicators for a number of conditions. That data did not appear to be used in assessing compliance with this provision. <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 continue the work in developing clinical indicators, conduct audits, and review the data obtained through those audits.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility assessed compliance by reviewing the internal and centralized systems that tracked the timeliness of annual and quarterly assessments. Those systems and data are discussed in section H1. The proposed section H guidelines indicated that the health status was discussed in the annual ISP and ISPA as identified by the IDT and a plan was developed to address the needs of the individual. Additionally, the facility tracked data in development of the identified health plan. The monitoring team agrees that the ISPs and ISPAs are integral to monitoring health status. To that end, the participation of primary care providers must improve. As noted in previous reports, the facility must monitor both acute changes and chronic long-term disease by linking the current monitoring systems. Monitoring health status requires a number of processes, reviews, and evaluations due to the need to monitor both acute changes and chronic long-term disease. LSSLC had a number of processes in place at the time of the compliance review that were capable of monitoring health status if properly executed: • Risk assessment • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy), • Acute assessments via sick call • Reports of acute changes via the daily clinical meetings and other status change meetings • ISPA Process • Medical databases (preventive care, cancer screenings, seizure management) • Pneumonia Review Process • Internal/external medical audits	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Chart audits completed as part of the medical quality program While a number of good systems were in place, the monitoring team identified a number of concerns related to current processes and systems: • The Pneumonia review process was in the early stages and lacked the ability at the time of review to provide meaningful oversight. • Risk identification and mitigation continued to present challenges for most disciplines. Medical assessments generally lacked risk assessments. • The lack of primary provider participation in the ISP process contributed to a lack of medical participation in the overall risk process. • The Annual Medical Assessments, in many instances, lacked appropriate plans. Developing a comprehensive format to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The effective monitoring of health status requires proper oversight of risk assessment and provision of medical care. This will require a robust medical quality program. Many of the aforementioned processes were not fully developed and/or implemented at LSSLC resulting in a system that did not adequately and consistently monitor health status. <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 primary medical providers should document a through discussion of risk assessment and mitigation. 2. PCP participation in ISPs and ISPAs should improve. 3. The facility must continue to develop and refine the medical quality program as discussed in section L3.	
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.	In order to assess this area, the QA nurse met with clinical disciplines to determine if clinical indicators were developed. Clinical indicators were developed for aspiration, constipation, diabetes mellitus, enteral feedings, seizures, and UTI. The facility also developed a Pneumonia Review Committee to review each case of pneumonia and make recommendations about supports. An additional question was added to the external medical reviews related to updating of the APL relative to a change in diagnosis. A total of 18 charts were audited. Eighty-six percent of the records were found to be in compliance having evidence that treatments and interventions were modified in response to a change in diagnosis.	Noncompliance

#	Provision	Assessment of Status	Compliance
		This provision addresses the need to develop systems that have the capacity to identify changes in status and modify treatments in response to those changes. At the time of the compliance review, there was the potential to track some changes via the daily patient care meetings, unit meetings, ISPAs, and other meetings discussed above. Clinical indicators would provide the objective means of assessing the adequacy of the treatments and interventions. Thus, the facility must continue the work of developing a comprehensive list of clinical indicators that will be used to determine when therapeutic outcomes are reached. Many of those will be based on clinical guidelines developed. These indicators will help determine when treatment plans must be altered. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	State office had developed a draft policy for provisions G and H. This policy had not been finalized at the time of the review. A local policy for the minimum common elements of care was implemented at LSSLC. <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, a state policy related to Provision H should be developed. LSSLC will need to revise its local policy once a state policy is issued.	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:** <u>Documents Reviewed</u>: ○ DADS Policy #006.1: At Risk Individuals dated 12/29/10 ○ DADS SSLC Risk Guidelines dated 4/17/12 ○ LSSLC Policy: Individual Support Plan Process revised 5/21/13 ○ List of individuals seen in the ER in the past year ○ List of individuals seen in the infirmary in the past year ○ List of individuals hospitalized in the past year ○ List of individuals with serious injuries in the past year ○ List of individual at risk for aspiration ○ List of individuals with pneumonia incidents in the past 12 months ○ List of individuals at risk for respiratory issues ○ List of individuals with contractures ○ List of individuals with GERD ○ List of individuals at risk for choking ○ Individuals with a diagnosis of dysphagia ○ List of individuals at risk for falls ○ List of individuals at risk for weight issues ○ List of individuals at risk for skin breakdown ○ List of individuals at risk for constipation ○ List of individuals with a pica diagnosis ○ List of individuals at risk for seizures ○ List of individuals at risk for osteoporosis ○ List of individuals at risk for dehydration ○ List of individuals who are non-ambulatory ○ List of individual who need mealtime assistance ○ List of individuals at risk for dental issues ○ List of individuals who received enteral feeding ○ List of individuals with chronic and acute pain ○ List of individuals with challenging behaviors ○ List of individuals with metabolic syndrome ○ List of individuals who were missing and/or absent without leave ○ List of individuals required to have one-to-one staffing levels ○ List of 10 individuals with the most injuries since the last review ○ List of 10 individuals causing the most injuries to peers for the past six months ○ Data reports regarding the submission of assessments for IDT review prior to annual ISP meetings ○ A list of all individuals at the facility with the most recent ISP meeting date and date ISP was filed.

	○ Draft ISPs and Assessments for Individual #344 and Individual #417, ○ ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #402, Individual #470, Individual #170, Individual #418, Individual #526, Individual #551, Individual #410, Individual #60, and Individual #128. <u>Interviews and Meetings Held</u>: ○ 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 Services ○ Stephani Sowell, Acting QIDP Coordinator ○ Gail Husband, ADOP ○ Mary Bowers, CNE ○ Stephen Webb, HRO <u>Observations Conducted</u>: ○ Observations at residences and day programs ○ Incident Management Review Team Meeting 7/14/14 and 7/17/14 ○ ISP preparation meeting for Individual #116 and Individual #163 ○ Annual IDT Meeting for Individual #344 and Individual #417 ○ Castle Pine Unit Meeting 7/15/14 ○ Castle Pine LOS and Protective Device Review 7/15/14 ○ Morning Clinical Services Meeting 7/17/14 ○ Executive Safety Committee Meeting 7/17/14
	Facility Self-Assessment: LSSLC submitted its self-assessment updated 3/13/14. 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. For example, to assess compliance with I1, the facility: 1. Reviewed a sample of 16 IRRFs to ensure all individuals had a risk rating for each category (updated annually or as needed). 2. Reviewed 6 annual action plans for individuals rated at medium or high risk to ensure action plans were current and included all relevant information. 3. Reviewed the assessment database to determine if assessments were completed prior to the

	annual ISP and posted to the share drive within 10 business days of the ISP. 4. Reviewed facility At Risk policy 5. Reviewed CTD records for compliance with training requirements. 6. Reviewed documentation for 49 individuals hospitalized during the last three months for ISP addenda/Change of Status within the last 3 months to determine if appropriate assessments and re-evaluation of risk ratings were completed within the expected five-day timeframe for change in status. The facility had an adequate self-assessment process in place. Additional work towards compliance with section I was focused on findings from the self-assessment. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed with the facility's ratings for section I.
	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. Since the last review, the facility had implemented a number of procedures to address risks including a root cause analysis protocol implemented following a diagnosis of pneumonia. Corrective action plans were developed to address the high incidence of falls and skin breakdown at the facility. The CNE and QA staff had provided additional training on change of status expectations related to the risk threshold data and risk database. The monitoring team observed the risk identification process at two ISP meetings. Each discipline presented relevant information included in the IRRF during the risk determination process. Although a lot of information was read from the IRRF, little time was spent engaged in discussion that might have aided the IDT in developing integrated supports. Both IDTs reviewed supports that were already in place and agreed to continue most supports without discussing how those supports might be modified to result in better outcomes for the individual. There was still a lot of focus on current diagnosis and little consideration of factors that might impact long-term risks (e.g., how family history, weight, medication side effects contribute to the risk of cardiac disease). The facility continued to monitor the submission of assessments prior to annual ISP meetings. Data indicated that there had been significant improvement in assessment submission, however, a review of current ISPs and supporting assessment showed that all ISPs in the sample were developed without up-to-date assessment information. Without current assessments available to the IDT for review, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings. As noted in section F, the facility did not have an adequate system in place to monitor supports. Teams were not consistently documenting the completion of assessments and resulting recommendations and supports were not monitored to ensure consistent implementation. 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. Provision I3 requires evidence that plans were implemented in a timely manner once risks were identified. The facility reported that due to the turnover in the QIDP department, ISPs were often not filed and available for implementation within 30 days of development. The QIDP Coordinator indicated that this was a focus area for the QIDP department. To move forward with section I: 1. 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. 2. 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. 3. 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. Since the last review, the facility had implemented a number of procedures to address risks including: • Implementation of a Pneumonia Event Root Cause Analysis Process (PERCA). The CNE had trained staff on the new process in May 2014. • Clinical staff met to review the status of individuals receiving enteral feeding. An ISPA form was developed to be completed prior to new G-tube placements. The new form included a number of prompts for discussion by the IDT. • A corrective action plan was developed to address the high incidence of falls at the facility. Fall prevention training was provided to Oak Hill and Lone Pine residential staff. • A corrective action plan was implemented to address skin integrity issues. Unit directors and home managers had begun completing monitoring tools for those individuals considered high risk for skin breakdown. The monitoring tool looked at implementation of the PNMP and related health care plans. • Habilitation therapy staff were not monitoring the use of suction toothbrushing.	Noncompliance

#	Provision	Assessment of Status	Compliance

Negative results were submitted to unit directors for corrective action.

- The CNE and QA staff had provided additional training on change of status expectations related to the risk threshold data and risk database.

The monitoring team observed two annual ISP 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 included in the IRRF during the risk determination process. Although a lot of information was read from the IRRF, little time was spent engaged in discussion that might have aided the IDT in developing integrated supports.

Since all team members have access to the IRRF and all assessments prior to the ISP meeting, the IDT should spend less time reading that information and more time discussing integrated factors that might impact risk ratings and warrant discussion. Both IDTs reviewed supports that were already in place and agreed to continue most supports without discussing how those supports might be modified to result in better outcomes for the individual. There was still a lot of focus on current diagnosis and little consideration of factors that might impact long-term risks (e.g., how family history, weight, medication side effects contribute to the risk of cardiac disease).

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 was tracking submission of assessments by discipline. Data submitted by the facility indicated compliance with this mandate had improved significantly. The table below shows the percentage of assessments submitted 10 days prior to the risk discussion by discipline for February 2014 through June 2014.

Discipline	Submitted on time (at least 10 days prior to annual IDT meeting)				
	Feb 2014	Mar 2014	April 2014	May 2014	June 2014
Medical	85%	78%	100%	100%	97%
Psychiatric	64%	93%	53%	100%	100%
Nursing	100%	93%	96%	96%	94%
Dental	89%	89%	89%	96%	97%
QDRR	78%	100%	93%	63%	82%
Psychological	74%	85%	82%	96%	94%
Hab. Therapies	96%	92%	96%	95%	100%
Communication	9%	17%	73%	80%	78%
Nutrition	74%	96%	82%	100%	88%

#	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 not all assessments were being submitted prior to annual ISP meetings in some cases. The sample included Individual #402, Individual #470, Individual #170, Individual #410, Individual #418, Individual #128, Individual #551, Individual #60, and Individual #526. Zero (0%) of nine individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. All ISPs in the sample included general strategies to address identified risks, but in some cases, not all assessments were submitted prior to the determination of risk ratings. Thus, IDTs did not always have updated clinical data to drive the risk discussion. For example, Individual #344's recommended vision assessment was not completed prior to her ISP meeting. The QIDP reported that she had five falls over the past year. Supports were developed without consideration of how her vision might be contributing to her high number of falls. 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 #460's IRRF indicated that she was at medium risk for choking. She was placed on NPO status in 2010 after an MBS indicated that she was at risk for silent aspiration due to her inability to swallow or cough to clear her throat. A g-tube was placed at that time. Given the MBS assessment that placed her at high risk for choking, she should have remained at high risk unless another assessment was completed and that determination changed. She was also rated as medium risk for skin integrity, however, she was non-ambulatory and incontinent. She relied completely on staff for repositioning • Individual #410 was rated as low risk for falls even though he had three falls the previous year with one resulting in a serious injury. He was rated as low risk for fractures, yet he had three falls the past year and wore a helmet 24 hours a day for protection due to his lengthy history of injuries due to his SIB. He had a serious injury this year when he punched his hand through a window and another incident where he shattered a car window with his head. Documentation from January 2014 indicated that he had 11 injuries due to head banging in the past year requiring four MRIs. He was at high risk for fractures. • Individual #238's IRRF was last updated on 12/20/13. He was rated as medium risk for constipation. He had a long history of constipation and was taking three medications to control his constipation. In January 2014, he was hospitalized	

#	Provision	Assessment of Status	Compliance
		with an impaction. He was rated as medium risk for choking and aspiration. In January 2014, he had an MBS that indicated that he had Level 3 dysphagia. In March 2014, he was hospitalized for g-tube placement. His IDT met to discuss his change in status, but failed to update his IRRF or IHCP. He was also rated as medium risk for falls, though it was noted that he had nine falls the previous year and his physician noted that he "has a significant gait deviation and maybe somewhat unsteady on occasion." His IDT met in May 2014 to review three additional falls. The team rated him as high risk for falls, but again, failed to update his IRRF or IHCP. • Individual #402 was rated as medium risk for constipation, though she had a diagnosis of chronic constipation, took medication for constipation, took two other medications with a side effect of constipation, and was non-ambulatory. The team agreed that she was medium risk because she remained stable throughout the year. Nursing records, however, indicated that she had required enemas during the past year. She was at high risk for constipation given her history and contributing factors. 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.	
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 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 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. 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 always possible to determine if assessments were completed or if recommendations from assessments were incorporated into supports and tracked for efficacy. For example,	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The incident management department had identified a trend of falls for Individual #90. She continued to appear on the list of individuals with the highest number of falls in quarterly trend reports. The QA/QI Committee and the Executive Safety Committee were reviewing her fall data due to the significant number of falls in the past year. A review of her file showed that the IDT failed to consistently review her fall data and follow-up on recommendations made to address her falls. On 6/20/14, the IDT met and reviewed her fall data (19 falls over the past year/7 falls in May 2014). There was no indication that the team was monitoring her supports, met in a timely manner when she continued to fall, or revised supports when not effective. Her IDT submitted a referral to the PNMT on 6/18/14, at the time of the monitoring visit (a month later), the PNMT had still not addressed the referral. 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 identified risk. Findings by discipline are summarized below. <u>Nursing</u> Based on the records selected by the monitoring team for review, 12 individuals that were due their annual ISP (February 2014-June 2014) had a corresponding ISP. Six of the 12 individuals were new admissions. Seven of 12 (58%) of the records included a completed Admission/Annual Comprehensive Nursing Assessment/Nursing Physical Assessment, and the required accompanying documents. Of the seven, five (71%) of the records included a completed Admission/Annual Nursing Assessments to assist the team in developing appropriate plans to adequately address the individual's health care needs. <u>Medical</u> See section L and N regarding the identification of medical risk factors. <u>OT/PT</u> Based on a review of 28 individual records for whom communication assessments had been completed to address the individuals' at risk conditions, 28 (100%) included an adequate OT/PT assessment to assist the team in developing an appropriate plan. Based on a review of 26 individual records, only 14 had been provided a current and appropriate communication assessment. Each of the 14 had addressed the individuals' at risk conditions, however, but it was of concern that many did not have the necessary information related to communication for risk assessment and the development of a comprehensive and well-integrated ISP. Although progress was noted, the facility did not yet have an adequate system in place to ensure that all recommended assessments were completed in a timely manner.	

#	Provision	Assessment of Status	Compliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner, if indicated by the risk status. IDTs were not tracking the completion of assessments and documenting resulting recommendations. Documentation of plan implementation was not consistent. Thus, it was not always possible to determine if IDTs implemented all recommendations from assessments within 14 days. For the QIDP monthly reviews, the QIDPs were not consistently documenting implementation of action steps or reviewing status of IHCP outcomes. For example, • Individual #170 had outstanding referrals for a bone density scan, EKG, and dietary consultation. There was no evidence that the assessments were completed, or if completed, that the team reviewed recommendations. • Individual #526's IDT recommended an updated neurological assessment. It was not evident that a consultation with the neurologist was completed, or if completed, the team reviewed any recommendations. His OT assessment also recommended consultation with a dermatologist. There was no documentation that consultation was obtained. 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. 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.	Noncompliance

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 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 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 ten 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 Copy of new restraint policy dated 7/1/14 o Color copy of section J QA/QI report for the last six months. o Name of any individual prescribed Reglan.

	○ Five examples of psychiatric QA and monthly QA averages for all documents reviewed by psychiatry clinic. ○ Five examples of polypharmacy justification. ○ All information presented, doctor's notes and documentation from neurology clinic on 7/15/14 regarding Individual #210, Individual #521, Individual #169, and Individual #120. ○ All information presented, doctor's notes and documentation regarding Dr. Vyas' clinic 7/16/14 regarding Individual #279 and Individual #126. ○ All information presented, doctor's notes and documentation regarding Dr. Vyas' clinic 7/14/14 regarding Individual #43 and Individual #380. ○ All information presented, doctor's notes and documentation regarding Doug Douglas, P.A. clinic 7/16/14 regarding Individual #147. ○ All information presented, doctor's notes and documentation regarding Doug Douglas, P.A. clinic 7/17/14 regarding Individual #354, Individual #424, and Individual #170. ○ Data regarding timeliness of psychiatric quarterly assessments. ○ Five examples if IRRF submissions. ○ Data regarding timeliness of IRRF submissions. ○ Documentation from the ISP dated 7/14/14 regarding Individual #417. ○ 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 ○ For the following individuals: Individual #147, Individual #417, Individual #517,

	Individual #169, Individual #365, Individual #306, Individual #574, Individual #410, Individual #170, Individual #91. <u>Individual Interviews and Meetings Held</u>: o Dr. Jafri, facility dental director o Shyam Vyas, M.D., psychiatrist o Sunil Cherry, M.D., neurologist o Judd Williamson, R.N., Psychiatric Nurse o Robin McKnight, MA, LPC, BCBA, Director of Behavioral Health Services o Mary Bowers, R.N., Chief Nursing Executive o Jodella Winn, psychiatry administrative assistant, Judd Williamson, R.N., and Caleb Nelson, LVN o Jessica Noteware, Pharm.D., clinical pharmacist o Ron Corley, M.D., medical director and Andra Self, clinical services director <u>Observations Conducted</u>: o Dr. Vyas' clinic 7/14/14 and 7/16/14. o Doug Douglas, P.A. clinic 7/16/14 and 7/17/14. o Neurology clinic 7/15/14. o ISP dated 7/14/14 regarding Individual #417. o Desensitization Meeting o Polypharmacy Committee Meeting o Pharmacy and Therapeutics Committee o Clinical Services Meeting o Observation of individuals in various home settings o Pretreatment sedation meeting
	Facility Self-Assessment: LSSLC 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 12 provision items: J1, J2, J6, J7, J8, J9, J10, J11, J12, J13, J14, and J15. The monitoring team agreed with 10 of these J1, J2, J6, J7, J8, J10, J11, J12, J13 and J14. The monitoring team did not agree with the facility self-assessment rating of substantial compliance in J9 or J15.

	Summary of Monitor's Assessment: Psychiatry services at LSSLC made progress towards substantial compliance. The facility was found to be in substantial compliance with 10 of the 15 items in this provision of the Settlement Agreement. Over half of the individuals residing at the facility received psychopharmacologic intervention (177 of 328, 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 .93 total FTE available. The two 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. Since the previous monitoring review, the facility made the transition from verbal/dictated documentation to electronic documentation utilizing a prepared shell. While the initial transition to electronic documentation was laborious, it will result in a time saving for the providers as it cuts down on redundant documentation. It was noted that, even with a reduction in FTE providers, psychiatry staff had managed to attend ISP meetings and other committee meetings. It was noted that psychiatry clinic staff were doing an excellent job scheduling and utilizing current resources to their full capacity. 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, behavioral health, nursing, QIDP, direct care staff, and the individual). Collaboration with neurology had continued, however, this remained a challenge due to psychiatry schedules. In an effort to provide increased collaboration, the facility and the consulting neurologist reported plans for his attendance at polypharmacy committee meeting in an effort to review combination polypharmacy (i.e., polypharmacy resulting from treatment with multiple antiepileptic medications in addition to psychotropic medications). Psychiatry clinic administrative staff was responsible for neurology clinic scheduling and coordination. Given the paucity of collaboration between neurology and psychiatry during this monitoring period, this provision remained in noncompliance in disagreement with the facility self-assessment. 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 consistently located on the PBSP document. As such, this provision remained in noncompliance in disagreement with the facility self-assessment.

	During this monitoring period, the facility achieved substantial compliance in J11. This was due to ongoing efforts by the facility staff to review polypharmacy regimens inclusive of those regimens meeting criteria for "combination polypharmacy." The facility had made strides with regard to the reduction of polypharmacy. There were several areas where the facility was able to achieve or maintain substantial compliance ratings (e.g., J1, J2, J6, J7, J8, J10, J11, 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, behavioral health) that were impeding this. Approaching this section as an isolated task list will not achieve the desired results, instead, a comprehensive, collaborative, integrated psychiatric service is required.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications LSSLC had a total of .92 FTE (full-time equivalent) psychiatrists/physician's assistant. All physicians who were responsible for providing psychiatric treatment were board certified in general psychiatry. One physician was also board eligible in child and adolescent psychiatry. The physician's assistant had significant experience in the treatment of psychiatric disorders, and had experience in the treatment of individuals with developmental disabilities. As such, the staff were qualified. The facility had designated a lead psychiatrist. Experience Of the two part-time physicians, one had been providing care at the facility for over four years. A second part-time physician had been providing care at the facility for over two years. The physician's assistant had a history of providing services at the facility and had returned to clinical duty at the facility over two years ago. Given the number of part-time providers, it will be a challenge for the physicians to effect IDT integration. Practicing psychiatry in an SSLC is different than clinical practice in other settings. It may be helpful to provide the newer physicians with some mentoring from other physicians who are more experienced in the supports and services living center model. The facility developed a "pearls of wisdom" book in an effort to assist psychiatry staff in their transition to the supports and services center model. It was reported that this was beneficial to a psychiatric locum tenens provider, board certified in general psychiatry, who was retained to provide services for approximately one month during this monitoring period. Ultimately, the facility will need to continue the development of quality assurance monitoring inclusive of peer review to determine compliance with policy and procedure, documentation requirements, and to ensure the provision of services in accordance with	Substantial Compliance

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		generally accepted practices. Monitoring Team's Compliance Rating Based on the qualifications of the psychiatrists and the physician's assistant at LSSLC, this item is in substantial compliance in agreement with the facility self-assessment.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated The psychiatrists continued to perform comprehensive psychiatric assessments per Appendix B. At the time of this visit, 100% of individuals participating in psychiatry clinic had completed comprehensive psychiatric assessments. Evaluation and Diagnosis Procedures Overall, evaluation and diagnostic procedures were satisfactory and within generally accepted professional standards of care (e.g., interview, staff meetings, record reviews). In previous monitoring reviews, variability in the quality of case formulations or description of what led the psychiatrist to make a specific diagnosis was discussed. During this monitoring period, there was some variability in the quality of documentation. This was attributed to the transition to electronic documentation, where providers are required to type their findings into a shell document rather than dictate. Psychiatry clinic staff continued to systematically review comprehensive psychiatric assessments. In doing so, they noted areas where documentation was routinely deficient. In an effort to address this, the newly implemented electronic shells included written prompts for the provider. In some cases, the providers were simply answering the questions with yes/no answers rather than providing rich detail generally present in documentation transcribed from dictation. This was discussed during the monitoring review. The psychiatry clinic staff were planning to discuss this with the providers, and change the prompts to discourage solely yes/no responses. Clinical Justification All individuals prescribed psychotropic medication had a five-axis diagnosis documented, and appropriate case formulations or descriptions of what led the psychiatrist to make a specific diagnosis were noted. A review of 15 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. More recently, psychiatry clinic staff had enhanced this documentation review providing weighted percentages to each documentation area (e.g., target symptom data review was worth 6%, past psychiatric history 4%). Per the review, the average annual assessment score for May 2014 was 87%, and for June 2014 95%. With regard to quarterly	Substantial Compliance

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		psychiatric assessments, the average score for May 2014 was 93% and for June 96%. Given the above, it was apparent that the facility psychiatric staff continued attempts to improve their evaluations and the documentation associated with them. <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 177 individuals participating in psychiatry clinic, individuals were seen quarterly. Per data received, from January 2014 through June 2014, 100% of individuals requiring quarterly psychiatric clinics were seen in clinic. It was noted that while these occurred during the quarter, there were a percentage of assessments that were documented as "on time." This indicated the final assessment, inclusive of documentation, was completed within 10 business days of the assessment date. During this monitoring period, on average, 80% of assessments were completed "on time." Per the monitoring team's review of the data provided, five quarterly psychiatric clinic reviews were outdated, with four individuals last seen in February 2014 and one in January 2014. As such, 2% of the individuals participating in psychiatry clinic were delinquent with regard to quarterly psychiatry clinic follow-up. <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, implement documentation guidelines for the psychiatrists, and implement electronic documentation. <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 transition to electronic documentation. The facility psychiatric staff had continued peer review and quality improvement monitoring of documentation. In addition, there were improvements noted in the tracking of services provided and with regard to scheduling. 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	<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 10 records, all had diagnoses noted in the record.	Noncompliance

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	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.	Individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). A review of 10 records by the monitoring team revealed nine examples of PBSP. The record of Individual #147 did not include the BSP. Of the other nine examples, seven included signatures of the psychiatrist (70%) on the PBSP document. It was difficult to determine the psychiatrist's input and/or review of the PBSP outside of their signature on 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, the PBSP 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, behavioral health 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 was a transition to electronic documentation utilizing a shell document prepopulated with historical information (e.g., laboratory examinations, MOSES and DISCUS scores, previous diagnoses). This transition was laudable, and while initially labor intensive, should reduce the documentation burden over time. In the interim, there were some documentation issues attributable to the transition. Specifically, prior to the transition, providers were required to dictate their information for transcription. Dictation encouraged the providers to provide enhanced information, however, with electronic documentation, some of the providers were entering less information in response to specific prompts. This was discussed with psychiatry clinic staff during the monitoring visit. It will be important for collaboration to continue between behavioral health 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 behavioral health 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	

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		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. <u>Emergency use of Psychotropic Medications</u> The facility use of emergency psychotropic medication for individuals during periods of agitation/aggression had increased. During the previous monitoring period, there were seven incidents. For this monitoring period, there were 17 incidents. These 17 incidents were attributed to three individuals, with Individual #410 receiving emergency psychotropic medication on 14 of the 17 occasions. A review of the data revealed that in 13 of 17 events, the chemical restraint was ordered by the primary care physician as opposed to the psychiatrist. Per the facility self-assessment, documentation regarding 10 instances of chemical restraints was reviewed. Of these, all 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. Two of the 10 examples were ordered by or coordinated with the psychiatrist. And eight included restraint review and debriefing documents that were completed within 10 days as required by policy, an improvement over the previous monitoring review. This was consistent with the monitoring team's review of the documentation. There was cause for concern with regard to the number of restraints utilized in the case of Individual #410. This individual had 50 physical restraints and 14 chemical restraints documented during this monitoring period. It should be noted that some of the physical restraints were lengthy, lasting an hour or more. This individual had health conditions including a cardiac arrhythmia that could make extended physical restraint dangerous. This case should be reviewed by the IDT to determine if alterations to his treatment plan are necessary, or if he would be better served in a different setting. <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 only 70% of examples including signed PBSP documents. 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 increase in instances, with the majority of these instances attributable to one individual. Data review indicated that primary care physicians ordered 76% of chemical restraints administered. Given the issues outlined above, this provision will remain in noncompliance in agreement with the facility self-assessment.	

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		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. 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)	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Extent of Pretreatment Sedation</u> The facility reported a total of 93 instances of pretreatment sedation between 1/3/14 and 5/15/14. This was a reduction from the previous monitoring period where there were 97 instances. Data indicated that 10 of these instances were TIVA, with an additional six indicating oral sedation for a dental procedure. The remaining 77 instances were noted for various medical procedures. Interestingly, of the total of 93 instances of pretreatment sedation or TIVA, 70 (or 75%) were for individuals participating in psychiatry clinic who were prescribed psychotropic medications. <u>Interdisciplinary Coordination</u> In September 2012, the facility instituted a pretreatment sedation consultation process. This system was included in policy and procedure entitled "Client Management," dated 5/20/13. Per this policy, attempts must be made to treat individuals without sedation and/or restraints, if treatment attempts continue to be unsuccessful 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 revised 6/2/14 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, the consensus meeting regarding three individuals was observed. During the meeting, the staff in attendance performed a cursory review of the request and input provided by primary care, psychiatry, and pharmacy. It was concerning that this discussion was performed in the absence of the clinical pharmacist, and in the absence of a listing of all the medications that each individual was currently prescribed. The participation of the clinical pharmacist is vital to this process. Knowledge of the individual's prescribed medication is of paramount importance as this is the final review of	Noncompliance

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		the request, and at this juncture, a recommendation to adjust an individual's medication regimen to avoid over sedation could be further considered. Of the 10 examples available for review, 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 was simply a "rubber stamping" of the original request for sedation. As medications utilized for pretreatment sedation could result in unwanted challenging behaviors, sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness, or mistaken as side effects from the regular medication regimen, the need for communication regarding the utilization of pretreatment sedation must continue. <u>Monitoring After Pretreatment Sedation</u> A review of documentation for 10 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. <u>Desensitization Protocols and Other Strategies</u> 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 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	

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		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 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 continued outreach into the individual's homes with regard to encouraging oral hygiene. In addition, dental appointments were being scheduled in Outlook, so that behavioral health staff were aware of a scheduled appointment and could attend in order to assist with the process. Documentation indicated that behavioral health staff had attended dental clinic with 29 individuals. Of these, the dentist had recommended 10 individuals for desensitization activities. It was noted that there were plans for all 29 individuals on this list to have a "Dental Desensitization Restraint Plan" implemented. The newly developed "Dental Desensitization Restraint Plan" was created as an addendum to the individual's ISP, and was to be authored in the course of reviewing medical or dental restraints per policy and procedure entitled "Use of Restraint" dated 6/4/14. The plan included consideration of the justification for the proposed restriction, least intrusive alternatives that had been tried, risks, desensitization activities/strategies that are being utilized or that have been attempted, and the nature of the proposed restraint (e.g., pretreatment sedation, TIVA). Completion of examples of this plan were pending at the time of this monitoring review. Given this emerging process, there was less focus on formal desensitization plans, and a greater focus on strategies to assist individuals. This was appropriate. <u>Monitoring Team's Compliance Rating</u> 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 was making efforts to identify and assess individuals with regard to the need for a "Dental Desensitization Restraint Plan." In order to move toward substantial compliance, it is recommended that over the next six months, the facility focus on authoring and implementing the newly developed plans. It is also recommended that they address desensitization with regard to the use of sedation for medical procedures.	

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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 (177 individuals) received psychopharmacologic intervention requiring psychiatric services at LSSLC as of 7/14/14. There were two part-time psychiatrists and one physician's assistant totaling, per the facility self-assessment, one FTE. Calculations performed by the monitoring team utilizing data provided revealed the resources at .93 FTE. During this monitoring period, a locum tenens provider, board certified in general psychiatry, was also on staff through 4/25/14, providing one additional FTE during this period. 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 eligible in child and adolescent psychiatry. There was a lead psychiatrist designated. Per the facility self-assessment, psychiatric resources were thinly stretched. Efficiency in the use of resources and creative scheduling allowed the psychiatric practitioners to complete clinical duties, attend ISP meetings, and attend committee meetings. In addition, the psychiatry staff developed electronic documentation shells in an effort to reduce the time the providers spent completing documentation. 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 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 37 available clinical hours weekly. 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 49 of 90 or 54% of annual ISP meetings since January 2014), attend required committee meetings, and participate in the development of the PBSP. The self-assessment also	Noncompliance

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		indicated that psychiatrists were able to collaborate with neurology, and although somewhat improved, remained an area of deficiency. See the discussion under J15. Data provided via the self-assessment differed from the data provided via the document request which indicated that between 1/3/14 and 5/19/14, there were a total of 55 ISP meetings with documentation indicating that psychiatry was present at 45 meetings (81%). 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 148 psychiatric clinical resource hours per month, with a caseload of 177 individuals, there were enough hours for each individual to have approximately 50 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. <u>Monitoring Team's Compliance Rating</u> Due to the lack of sufficient psychiatric resources to provide the services required, this provision remained in noncompliance. This was in 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	<u>Policy and Procedure</u> A review of the facility's current policy and procedure manual revealed a document entitled "Psychiatry Services Procedure Manual" dated 5/9/14. Per this document, which was reportedly based on the overarching DADS psychiatric services policy, a psychiatric evaluation must follow the format of Appendix B. In addition, policy and procedure designated that documentation must be completed and filed on the facility share drive no later than 10 days prior to the respective annual IS. Per the facility self-assessment, the facility had added prompts to the form in order to improve documentation. These prompts	Substantial Compliance

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	current, generally accepted professional standards of care, as described in Appendix B.	included, "Psychiatric Diagnosis…target symptom monitoring…derivation of psychiatric symptoms…statements which reflect collaboration between psychiatry and psychology…pharmacological intervention…risk/benefit discussion." <u>Evaluations Completed</u> A listing of all individuals evaluated per Appendix B was requested. This list contained the names of 181 individuals. As there were a total of 177 individuals receiving treatment via the psychiatry clinic, the facility psychiatric practitioners had completed 100% 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 100% included documentation of the risk/benefit analysis. <u>Review of Completed Evaluations</u> A review of nine other completed comprehensive evaluations revealed that these evaluations were completed between 3/18/14 and 5/14/14. (Note, these annual evaluations were not those in the list discussed above.) There were sample evaluations provided from all facility practitioners. The evaluations reviewed were improved over those reviewed for previous monitoring reports. There were improvements with regard to the quality of the collaborative case formulation, the justification of diagnoses, the generation and documentation of the behavioral-pharmacological hypothesis, and identification of non-pharmacological interventions outside of the PBSP. In general, the physicians followed the required format, and per interviews with psychiatry clinic staff, the transition to electronic documentation, while reducing paperwork overall, had not been without challenges. The psychiatry clinic staff had been doing extensive preparation work to the shell documents in order to ensure that they included necessary information prior to the physician completion of the form. In an effort to ensure that physician documentation was complete, prompts had been added to the electronic document. In some cases, as stated in other areas of this report, this resulted in formulaic responses by the physician. This is likely a transitional issue that can be addressed by clinic staff by changing the prompts to an open ended question rather than a question that allows for a yes/no answer. 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	

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		work, review it from a quality perspective, and integrate what they learned from this process into their own practice at the facility. Monitoring Team's Compliance Rating 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 justifiable manner.	Reiss Screen upon Admission 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 behavioral health, the facility had performed Reiss Screens on all new admissions. The director of behavioral health 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. Timeliness of Reiss Screen Per the documents requested for this monitoring review, there were five individuals admitted to the facility since 2/5/14. Of these, all received Reiss Screening following admission. Of these, all individuals were referred for a comprehensive psychiatric evaluation. Reiss Screen for Each Individual (excluding those with current psychiatric assessment) The total facility census was 328, with 177 individuals enrolled in psychiatry clinic. Therefore, 151 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, 44 individuals had "N/A" with regard to Reiss Screening. Of these, all were participating in psychiatry clinic. Reiss Screen for Change in Status Data regarding the use of the Reiss Screen for individuals who have experienced a change in status indicated that the instrument was last utilized to assess an individual due to a change in status in 1/25/14. There were no reported Reiss Screens for change of status during the current monitoring period.	Substantial Compliance

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		Referral for Psychiatric Evaluation Following Reiss Screen Per an interview with psychiatry clinic staff and a review of facility based policy and procedure regarding psychiatric services, the "Psychiatry Services Procedure Manual" dated 5/9/14 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. Monitoring Team's Compliance Rating The facility made strides with regard to policy and procedure revision, 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 consistency in the utilization of the Reiss Screen as noted above, this provision is in substantial compliance in agreement with the facility self-assessment. For this monitoring period, data regarding the utilization of the Reiss Screen for those individuals who have experienced a change in status were not available. In order to maintain substantial compliance, these data must be provided for review and included in 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.	Policy and Procedure 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. 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	Substantial Compliance

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		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 nine examples provided for review that these were performed collaboratively, and per observation and staff report, they were performed in the presence of the team members with the benefit of documentation and input from other disciplines. <u>Integration of Treatment Efforts</u> There were marked improvements with regard to integration between psychiatry and behavioral health. There were opportunities for interaction between behavioral health 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 behavioral health to analyze the data and present hypotheses for improved clinical utility. Data collection practices are also discussed in section K. <u>Collaborative Diagnostic Formulations</u> A review of the comprehensive psychiatric evaluations of nine individuals revealed that all contained a case formulation. In all of the examples, there was documentation of input by behavioral health 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 #101: Per the comprehensive psychiatric evaluation dated 5/13/14, documented as completed in collaboration with the IDT, each psychiatric diagnosis was reviewed and particular symptomatology that the individual exhibited indicating criteria for the disorder was discussed. Per the evaluation, treatment modalities were reviewed, as were factors that could result in decompensation,	

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		risks of medication, and risks of illness. Polypharmacy justification was not included because the individual did not meet criteria for polypharmacy. This individual may benefit from a richer review of and non-pharmacologic interventions. Per the facility self-assessment, 10 Comprehensive Psychiatric Assessments were reviewed. Of these, data indicated 100% included a case formulation, 100% 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, interventions, or supports to	<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 83 records for individuals prescribed psychotropic medications who had an PBSP reviewed 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 90% of the PBSP sampled included the psychiatrist's signature on the document indicating review and input into the plan. A review of 10 records by the monitoring team, however, revealed nine examples of PBSP. The record of Individual #147 did not include the PBSP. Of the other nine examples, seven included signatures of the psychiatrist (70%) 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 contrast to the facility self-assessment. To meet the requirements of this provision item, there needs	Noncompliance

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	address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	to be indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. Given the presence of the IDT in psychiatry clinic, the monitoring team suggests that the PBSP should continue to be reviewed annually during regularly scheduled quarterly clinic, with additional reviews as clinically indicated. The review of this document should be noted in the annual evaluation, with the psychiatrist's signature present on the final document. Documentation of psychiatric attendance at IDT, ISP, and PBSP meetings was reviewed. Between 1/3/14 and 5/19/14, there were a total of 55 ISP meetings with documentation indicating that psychiatry was present at 45 meetings (81%). This was a reduction from a total of 110 ISP meetings reported in the previous monitoring report. Documentation indicated that for the 10 meetings that psychiatry did not attend, psychiatry clinic staff attended in their stead. Furthermore, documentation indicated that when the physician did not attend, it was because they were not present at the facility on the day of the meeting. 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 10 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 #306 - "continue with his training program to help him with communication skills…become involved in his gardening when the season is appropriate... positive reinforcement with verbal praise and attention such as going for a walk, playing ball, throwing horseshoes…giving him caffeine free diet soda pop." There were other examples where improvements were needed. For example: • Individual #169 - "continue encouraging participation in activities on dorm and classroom…encouraging family participation…other interventions such as speech, sensory, communication, counseling, CBT, environmental." This particular example was not individualized, and did not note interventions that would be interesting to this individual. 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 behavioral health, 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 behavioral health 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 consistently evident in the document review, this provision was rated in noncompliance in disagreement with the facility self-assessment. In order to move toward substantial compliance in is recommended that over the next six months the facility focus on: 1. ensuring consistent documentation of the psychiatric review and input into the PBSP inclusive of their signature on the document. 2. the identification and documentation of non-pharmacological interventions.	

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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.	Policy and Procedure 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 5/9/14 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. Quality of Risk-Benefit Analysis Per discussions with facility staff, the process of psychiatry documentation of risk/benefit analysis and description of other alternative treatment strategies had continued, however, there had been a change with regard to the method of documentation. Previously, the psychiatrists had dictated all information. In the intervening period, the facility had implemented electronic documentation. The psychiatry clinic set up shell documents that the providers could type into. This was an effort to reduce duplication of information over time and reduce the paperwork requirements. The implementation of this process was time consuming initially, however, it was apparent that this process will have long term benefits with regard to physician documentation.	Substantial Compliance

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		In the transition process, the shell documents included prompts for the providers such that they would respond to questions regarding psychiatric care. This included, but was not limited to the risk/benefit analysis for treatment with psychotropic medications. A review of documentation revealed that in some cases, the providers had simply responded to the queries with yes or no answers, and did not provide the rich documentation they had previously provided via dictation. This was discussed with psychiatry clinic staff during the monitoring visit. The clinic staff planned to address this. Per the facility self-assessment, 10 of a total of 83 records (12%) of records for individuals who received a comprehensive psychiatric assessment between 1/1/14 and 6/9/14 were reviewed to determine if the content of documentation included a risk/benefit analysis. In addition, 10 records were reviewed to determine the presence of this documentation in the ISP and or psychiatric assessments. Data indicated that, of the records reviewed for psychiatric documentation, 100% contained risks regarding a specific medication, 100% included information regarding the risks of the mental illness, and 100% included documentation of the risk/benefit discussion. Additional data revealed that, of the additional 10 records, 70% included documentation of the risk/benefit discussion in the ISP and 100% of psychiatric assessments included documentation of the risk/benefit discussion. A review of the records of 15 individuals at the facility who were prescribed various psychotropic medications (10 requested records onsite and five records provided via the document request regarding individuals most recently prescribed psychotropic medications) some variability in the quality of psychiatric documentation regarding this issue. The new shell format included a specific section for the documentation of the risk/benefit analysis, which was helpful. As noted above, however, the use of the prompts as question/answer did reduce the richness of the documentation noted in previous monitoring reviews. For example: • Individual #306 – the quarterly psychiatric review note dated 6/5/14 reviewed two medications that this individual was prescribed. The document indicated that regarding Risperidone, the medication was indicated for physical aggression. It further stated, "the risk of his illness versus being treated is that he was permitted to become manic again and it affects his sleep, his nutrition, and he may become more physically aggressive thus hurt someone or someone might hurt him." This section of the report, specifically dedicated to the risk/benefit analysis did not include risks that the individual could experience as a result of treatment with the specific medication. Other information included in the document reviewed the behavioral challenges that this individual historically displayed and specific psychiatric symptomatology. The document extensively reviewed medical history,	

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		laboratory examinations, and MOSES/DISCUS scores. Risks, including medication side effects and were reviewed. 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. • 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 facility had implemented the use of the shell document such that the information can be entered into the shell during the clinic process. This progress with regard to documentation was laudable. The QIDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. 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	

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		treatments). Monitoring Team's Compliance Rating As noted above, the facility had developed 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. The facility self-assessment provided a substantial compliance rating for this provision, and 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.	
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.	Facility-Level Polypharmacy Review The facility had their initial monthly polypharmacy review committee 11/1/12. Per the facility self-assessment, the facility held polypharmacy committee meetings on a monthly basis during the current monitoring period, however, meeting minutes were not provided for May 2014 or June 2014. 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. Review of Polypharmacy Justifications Psychiatric providers were currently justifying polypharmacy in the comprehensive psychiatric assessment and quarterly psychiatric review. In response to the document request, polypharmacy justifications were provided for 39 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. During this monitoring period, the facility had begun to review polypharmacy attributed to antiepileptic medications prescribed for seizure diagnoses. These medications were not prescribed by psychiatry, however, did impact the polypharmacy data and medication regimens with regard to side effects and interactions. In an effort to address this polypharmacy, the committee had requested that the consulting neurologist attend polypharmacy meetings on a periodic basis such that these regimens could be reviewed. Per an interview with one of the consulting neurologists, he planned to attend. This will offer an additional opportunity for interaction between neurology and psychiatry. It was discussed at length during the previous visit and, given the issues noted above,	Substantial Compliance

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		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 polypharmacy meeting observed during this monitoring visit indicated that the facility was experiencing difficulty in their laudable attempt to review "combination polypharmacy," or polypharmacy related to AED medications, in the absence of the presence of the neurologist. In addition, as noted in previous monitoring reports, the psychiatrists and physician's assistant worked various schedules, as such, the provider was not present in the review to observe the discussion or provide additional information or insight into the rationale for the regimen. 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 during the monitoring visit, there was variability in documentation as compared to previous monitoring reviews. In the intervening period since the last review, psychiatric documentation had transitioned to an electronic format. In order to provide as much structure for the physician documentation as possible, the electronic form included prompts. Some of these prompts were written such that a yes/no answer could be provided. This reduced the amount of documentation provided overall. Previously, the psychiatric physicians dictated their opinions, and were more verbose and descriptive. It is laudable that the psychiatry department had implemented electronic documentation; however, this transitional issue must be addressed. • Individual #466 - documentation described each medication, the target symptoms and psychopharmacological rationale, including a review of potential side effects. The document also included the physician's plans for future regimen adjustments. This was a good example of justification for polypharmacy. <u>Review of Polypharmacy Data</u> Per the data provided, an average of 22% of the individuals participating in psychiatry clinic met criteria for polypharmacy. This was a reduction from 27% reported in the previous monitoring period. The data revealed a total of 12 individuals meeting criteria for intraclass polypharmacy. This was reduced from 14 in the previous monitoring period. There were 28 individuals prescribed three psychotropic medications and seven individuals prescribed four psychotropic medications. This was reduced from 29 and 15, respectively. Data from January 2014 indicated there were no individuals prescribed five	

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		or more medications. Currently, it was noted that three individuals were 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. <u>Monitoring Team's Compliance Rating</u> Psychiatry clinic staff had done a laudable job of authoring polypharmacy justifications. While there were some deficits in documentation, it was opined that this was due to the transition to electronic psychiatric documentation and the use of yes/no prompts. This was discussed during the facility visit, and staff indicated plans to address this concern. The facility had made ongoing strides to reduce polypharmacy, and there were efforts to both acknowledge and address polypharmacy related to antiepileptic medications inclusive of planning for the attendance of the consulting neurologist in polypharmacy review. One area in need of improvement was the attendance of the prescribing psychiatrist at the review. This will allow for much better discussion and review. In order to accomplish this, the meeting would have to rotate to accommodate physician schedules, which may not be feasible.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> In response to the document request for a spreadsheet of individuals who were evaluated with MOSES and DISCUS scores, the facility provided tracking information regarding the completion of both evaluations via a spreadsheet outlining completion dates of the assessments by nursing staff. For this monitoring period, it was noted that the assessments were generally performed in a timely manner, as was reported in the facility self-assessment. MOSES scales were being performed in the months of January and July. DISCUS scales were being performed every three months according an individualized schedule. Per discussions with the Chief Nurse Executive and the psychiatric nurse, the tracking document was accessible by the psychiatric nurse. <u>Training</u> A review of information regarding training for nursing staff provided for previous monitoring reviews revealed that a one hour and 15 minute block of time during pre-service orientation was assigned to MOSES and DISCUS training. Training included videos, instructions on completing the examination, instructions on completing the forms, and the authorship of care plans for individuals experiencing side effects from psychotropic medication. Documentation provided for previous reports included information regarding	Substantial Compliance

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		a 15 minute block of training regarding MOSES and DISCUS that was included in nursing annual inservice training. For this monitoring review, it was reported that there had been no additional training following completion of pre-service orientation. This was discussed with nursing administration during the visit. Staff verbalized plans to resume annual training regarding MOSES and DISCUS for nurse case managers. <u>Quality of Completion of Side Effect Rating Scales</u> In regard to the quality of the completion of the assessments, it appeared that for the set of scales provided (10 examples of each assessment tool), all were completed appropriately and included the signature of the psychiatrist. Per the facility self-assessment, a sample of 10 MOSES and 10 DISCUS revealed that 70% were reviewed and signed within 14 days. In addition, the facility self-assessment reported that in a sample of 10 records, documentation regarding review of both the MOSES and DISCUS assessment was included. This was also noted in the review of 15 records performed for this monitoring report. In the four clinic observations performed during this visit as well as the review of clinic documentation, MOSES and DISCUS scores were reviewed during clinic and documented as such. Currently, all MOSES and DISCUS instruments were entered into the Avatar system. Physicians and the physician's assistant were able to electronically enter their clinical opinion regarding the instrument and sign the document. Per interviews with facility staff, the Avatar system could, at times, be difficult to utilize. In an effort to ensure that documentation reaches the medical record, the psychiatry clinic staff printed the completed assessments and routed them to the appropriate staff for filing in the record. Four individuals were noted to have the diagnosis of Tardive Dyskinesia (TD). All were being followed by psychiatry. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or the absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. <u>Monitoring Team's Compliance Rating</u> Given the documentation of review of MOSES and DISCUS examinations during psychiatry clinic, this area will remain in substantial compliance. It was noted that there was increased attention to completion of the clinical correlation/evaluation section of the instruments, and/or documentation of the clinical correlation in psychiatric progress notes. For the facility to maintain this rating, there must be improvements with regard to	

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		completion and documentation of annual nursing inservice training regarding MOSES and DISCUS administration. In addition, it was noted that there were delays with regard to the physician review and signature of the MOSES and DISCUS assessments. For the facility to maintain this rating, completion rates, currently at 70% completed within 14 days, must improve.	
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 5/9/14, "state centers must ensure 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 5/9/14. 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 15 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 included prompts in the newly implemented electronic documentation shells for psychiatric providers to utilize when documenting. For example, in the record of Individual #440, the quarterly psychiatric review note dated 5/27/14 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 decrease in the total number of meetings held. Between 1/3/14 and 5/19/14, there were a total of 55 ISP meetings with documentation indicating that psychiatry was present at 45 meetings (81%). This was a reduction from a total of 110 ISP meetings reported in the previous monitoring report. Documentation indicated that for the 10 meetings that psychiatry did not attend, psychiatry clinic staff attended in their stead. Furthermore, documentation indicated that when the	Substantial Compliance

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		physician did not attend, it was because they were not present at the facility on the day of the meeting. Admittedly, 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 consistent with 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 they routinely included timelines for medication dosage changes or stressful life events. In addition, now that data presentation was improved, behavioral health 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 five individuals who were overdue for psychiatry	

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		clinic, please see the discussion in J2 for additional information. Given the total number of individuals participating in psychiatry clinic (n=177), only 2% of the clinic population was overdue for a clinical encounter. Per the facility self-assessment, 10 comprehensive assessments were reviewed. Of these 70% included a justified psychiatric diagnosis, 100% included target symptom monitoring, 100% included a derivation of psychiatric symptoms, 70% had data provided by behavioral health attached to the document, 100% included documentation indicating collaboration with other disciplines, 100% included nonpharmacological interventions, and 100% included symptoms identified for monitoring. This was consistent with the monitoring teams review of documents. <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 had made the transition to electronic documentation. This may take some time for providers to adjust, and the shell may require some edits in an effort to obtain best results. 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 5/9/14, "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	Substantial Compliance

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		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 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 improvements noted to the consent form. Specifically, the forms now included a space clearly indicating the individual's LAR with a telephone number. The individual and his or her LAR received not only a verbal discussion of the medication information, but if the LAR was not present (or present via telephone), a copy of the medication information was reportedly sent via mail. Copies of the information sent to the LAR were attached to seven of the 10 examples of informed consent documentation provided. <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 10 records revealed all records included documentation regarding annual medication consent. A review of 10 examples of informed consent documentation regarding new medication prescriptions revealed continued improvements with regard to physician documentation. Nine of the examples regarding new medication prescriptions included an attached signed ISPA addendum document regarding review of the proposed medication, with three of these indicating psychiatric attendance at the IDT. One weakness noted in previous monitoring reports was the documentation of alternatives	

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		to medication treatment and the rationale for not implementing alternatives at the time the medication was recommended. The consent for treatment with psychotropic medication form completed by psychiatry had been revised to include a section entitled, "document any non-pharmacological alternatives that exist and rationale for not implementing them at this time." During this monitoring review, there had been ongoing issues in this area. For example: • Individual #511 - "Other atypical antipsychotic medications have similar side effects." This did not describe the rationale for not implementing another agent at this time. It did not include non-pharmacological interventions. • Individual #126 - "Pharmacologic: Geodon/Abilify/Latuda." This did not describe the rationale for not implementing another agent at this time. It did not include non-pharmacological interventions. 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. In addition, the facility self-assessment indicated that 90% of the consent documents reviewed for the self-assessment included documentation of consultation with the clinical pharmacist. <u>Monitoring Team's Compliance Rating</u> The ongoing 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.	

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J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Policy and Procedure Per DADS policy, Psychiatry Services 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 dated 5/9/14 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." Individuals with Seizure Disorder Enrolled in Psychiatry Clinic There were 68 individuals participating in psychiatry clinic who had a diagnosis of seizure disorder. This was equal to the number of individuals reported during the previous monitoring period. Per the facility self-assessment, three individuals were seen in neurology clinic at the request of psychiatry. Primary care providers referred an additional 11 individuals to neurology clinic. The self-assessment indicated that the time lapsed from the date of the order for the consult to completion of the consultation for 13 examples was 24 days. Of the three examples referred by psychiatry, the self-assessment indicated that all included documentation of neurology/psychiatry collaboration. Of these, two collaborations were noted to have occurred in person, and one via telephone. There were, however, 26 neurology consultations regarding individuals participating in psychiatry clinic who had a diagnosis of seizure disorder during this monitoring period, indicating that collaboration between neurology and psychiatry occurred in 11% of the cases. For example: • Individual #574 was seen in neurology clinic on 5/22/14, following a request by his primary care provider. Per the consultation, Individual #574 was last seen in neurology clinic in February 2013. At that time, "there was some concern over behavioral issues and weaning of his Keppra. It was advised that it was okay to do this. However, by reviewing his medications, he remains on Keppra 750 mg twice a day. From talking with the nurse, he has been doing quite well from a behavioral standpoint…no seizures over the past year." The neurologist recommended continuing this individual's current AED regimen. Although this individual was participating in psychiatry clinic, prescribed medications such as Keppra that may exacerbate behavioral challenges and Tegretol, which can interfere with the	Noncompliance

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		metabolism of other medications, there was no notation of collaboration with the treating psychiatrist. There was a notation at the bottom of the document, which indicated that the reviewer agreed with the plan, however, the reviewer's signature was illegible. <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." In addition, it was reported that the consulting neurologist was scheduled to participate in polypharmacy meetings in order to review polypharmacy regarding antiepileptic medications. The consulting neurologist reiterated this plan. This will allow additional consultation opportunities between the specialties. 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, no observed patient encounters were performed in consultation with psychiatry. 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 identified, all had been seen in neurology clinic within the past year. This was an improvement over 14 individuals requiring annual follow-up identified in the previous monitoring period. Improvements in scheduling and clinic time management had resulted in 68 individuals receipt of annual neurological consultation. <u>Monitoring Team's Compliance Rating</u> While there were improvements noted with regard to policy and procedure outlining the process for psychiatry/neurology consultation, individuals receiving annual consultation, 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 disagreement 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. Improve the collaborative consultation and documentation thereof between	

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		psychiatry and neurology providers in a manner that will be sustainable. Plans for the consulting neurologist to participate in polypharmacy committee will allow for increased contact between the specialties, specifically for review of medication regimens.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Functional Assessments for: • Individual #97 (5/8/14), Individual #85 (3/3/14), Individual #252 (3/13/14), Individual #273 (11/18/13), Individual #287 (5/5/14), Individual #129 (2/5/14), Individual #192 (5/9/14), Individual #298 (11/20/13), Individual #392 (11/14/13), Individual #330 (10/29/13), Individual #176 (2/12/14), Individual #380 (3/26/14), Individual #170 (7/1/14), Individual #59 (10/1/13) o Positive Behavior Support Plans for: • Individual #97 (5/8/14), Individual #85 (3/3/14), Individual #252 (3/13/14), Individual #273 (11/18/13), Individual #287 (5/5/14), Individual #129 (2/5/14), Individual #192 (5/9/14), Individual #298 (11/20/13), Individual #392 (11/14/13), Individual #330 (10/29/13), Individual #176 (2/12/14), Individual #380 (3/26/14), Individual #170 (7/1/14), Individual #59 (10/1/13) o Six months of notes on PBSPs progress for: • Individual #97, Individual #85, Individual #252, Individual #273, Individual #287, Individual #129, Individual #192, Individual #298, Individual #392, Individual #330 o Full Psychological Assessments for: • Individual #287 (5/5/14), Individual #330 (10/29/13), Individual #380 (3/26/14), Individual #59 (10/1/13) o Annual Psychological updates for: • Individual #97 (5/8/14), Individual #85 (3/3/14), Individual #252 (3/13/14), Individual #273 (11/18/13), Individual #129 (2/5/14), Individual #192 (5/9/14), Individual #298 (11/20/13), Individual #392 (11/14/13), Individual #598 (4/9/14), Individual #322 (3/5/14), Individual #594 (5/6/14), Individual #294 (5/13/14), Individual #265 (3/25/14), Individual #279 (2/12/14), Individual #477 (4/30/14), Individual #215 (5/22/14), Individual #170 (7/1/14), Individual #176 (2/12/14) o Individual Support Plans (ISPs) for: • Individual #85, Individual #20, Individual #228, Individual #279, Individual #265, Individual #194 o Behavioral Health Services Department: Peer Review/ Behavioral Support Committee procedures, 4/22/14 o Training materials used to teach staff to implement PBSPs, undated o List of training conducted on PBSPs across homes, 1/14-5/14 o Data timeliness, IOA, and treatment integrity data from 1/14- 5/14 o Treatment Integrity/Staff competency measure, undated o Treatment Integrity/Staff competency measure test, undated

	○ PBSP readability scores, undated ○ Minutes from Behavioral Health Department meetings for the last six months ○ Minutes from peer review meetings from the last six months ○ List of individuals who are receiving counseling/psychotherapy, undated ○ Section K Presentation book, 5/14 ○ Section K action plans, 6/9/14 ○ Section K Self-Assessment, 6/24/14 ○ Data Inventory, 4/23/14 ○ Lufkin local restraint policy, 6/4/14 ○ List of individuals with a crisis intervention plan, undated ○ Data collection reliability spot checks form, undated ○ List of the date of each individual's annual psychological assessment, undated ○ List of all individuals with PBSPs and functional assessments, including date of last plan revision/review, undated ○ Spreadsheet of individuals most recent psychological assessment, undated ○ List of all behavioral health services staff and status of enrollment in BCBA coursework, undated <u>Interviews and Meetings Held</u>: ○ Robin McKnight, BCBA, Director of Behavioral Health ○ Robin McKnight, BCBA, Director of Behavioral Health; Mike Fowler, BCBA, Behavior Analyst; Kari Staley, BCBA, Behavioral Analyst; Kenneth Elerson, Behavior Health Specialist; Jill Harris, Behavior Health Specialist ○ Traci Swain, Behavioral Health Specialist; Karon Goolsby, QIDP; Annette Daniels, home manager 563A ○ Adam Williams, BCBA, Behavior Analyst ○ Todd Miller, Residential Services Manager; Mary Stovall, Oak Hill Unit Director; Kenneth Self, Woodland Crossing Unit Director; Julie Olivares, Lone Pines Unit Director <u>Observations Conducted</u>: ○ Pre ISP meeting for: • Individual #116 ○ Psychiatric Review Meeting • Individuals presented: Individual #279, Individual #126 ○ Restraint Reduction Meeting ○ Peer Review Meeting • Individual presented: Individual #203, Individual #91, Individual #126 ○ Behavior Support Committee (BSC) • Individuals reviewed: Individual #93, Individual #220 ○ PBSP treatment integrity collection • Staff observed: Kyeisha Foreman, psychology assistant • PBSP assessed: Individual #220

	○ IOA collection • Staff observed: Christi Wall, psychology assistant • PBSP assessed: Individual #74, Individual #594, Individual #555 ○ Pretreatment Sedation meeting ○ 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 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, K5, K6, K7, K9, and K11. The monitoring team's review of this provision was congruent with the facility's self-assessment. Finally, the self-assessment established long-term goals for compliance with each item of this provision. Because many of 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: There were several improvements since the last review, resulting in K9 being rated to be in substantial compliance. Additionally, the facility maintained substantial compliance on the six items (K2, K3, K5, K6, K7, and K11) that were in substantial compliance prior to this review. A summary of these improvements are listed below and described in detail below: • Continued 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) • Development of a database to measure data timeliness, inter-observer agreement (IOA), and

	treatment integrity level and frequency (K4/K10) • Consistent demonstration in the progress note that some activity (e.g., retraining of staff, modification of PBSP) had occurred when an individual is not making anticipated progress (K4) • Continued improvement in the quality of PBSPs (K9) • Demonstration that PBSPs were consistently implemented within 14 days of achieving necessary approvals and consent (K9) The areas that the monitoring team suggests that LSSLC work on for the next onsite review are: • Demonstrate that established minimum frequencies and levels of data collection reliability, IOA, and treatment integrity are achieved (K4, K10) • Ensure that counseling services consistently contain documentation of progress on treatment goals and contain all of the elements listed below (K8)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all 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 of the 15 staff (20%) that wrote PBSPs were BCBAs. Additionally, the director of behavioral health and the consulting behavior analyst were BCBAs. This is similar to the last report when 23% of staff that wrote PBSPs were BCBAs. All 15 staff that wrote PBSPs (100%) were either enrolled, or completed coursework, toward attaining a BCBA. This is same as the last review when 100% 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 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.	Noncompliance
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	The facility continued to be in substantial compliance with this item. At the time of the onsite review, the director of behavioral health services had a master's degree in counseling, was a licensed professional counselor, was a certified applied behavior analyst (BCBA), and had over 20 years of experience working with individuals with intellectual disabilities. Finally, under the director's leadership, several initiatives	Substantial Compliance

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	a consistent level of psychological care throughout the Facility.	have begun leading toward the attainment of compliance with this provision.	
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.	LSSLC continued its weekly internal, and monthly external, peer review meetings. The internal peer review meetings provided an opportunity for staff to present new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #203. There was active participation from the department's behavioral health specialists that appeared to result in the identification of several potentially useful strategies to address Individual #203's target behaviors. Additionally, Individual #91 and Individual #126, who were presented in previous peer reviews, were reviewed to ensure that past recommendations were implemented. Review of the minutes from internal peer review meetings indicated that the majority of staff that wrote PBSPs regularly attended peer review meetings. Additionally, meeting minutes indicated that internal peer review meetings occurred in 21 of the last 21 weeks (100%) from 1/7/14 to 5/27/14, and that once in each of the last six months, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item. In order to maintain substantial compliance, LSSLC will need to provide documentation that internal peer review occurred during at least 80% of the weeks reviewed, external peer review occurred during at least 80% of the months reviewed, and there was evidence of follow-up/implementation of recommendations made in peer review.	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	LSSLC continued to make steady progress in this area. More work, however, is necessary before this provision item can be judged to be in substantial compliance. One area of improvement was an increase in the flexibility of the data system. LSSLC utilized multiple data systems. These included the recording of frequency or partial interval recording of replacement and target behaviors in one-hour intervals, two-hour intervals, or for an entire shift. Some individuals in home 563A, for example, had partial interval data collection sheets (e.g., Individual #562) while others had frequency within interval recording (e.g., Individual #43), based on the frequently the of target behaviors. In all 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	Noncompliance

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	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.	psychologists to review data sheets during a shift and determine if DSPs were recording data at the intervals specified (i.e., data collection timeliness). LSSLC assessed data collection timeliness. They established the minimal acceptable level of data collection timeliness to be 80%, and the frequency of assessing data collection timeliness to be at least quarterly for each individual with a PBSP. Another improvement since the last review was the development of a database to track the level and frequency of data timeliness, inter-observer agreement (IOA), and treatment integrity (see K10). LSSLC reported that from 1/1/14 to 6/30/14 data collection timeliness averaged 71%, and 88% of the individuals with a PBSP had data collection timeliness collected at least quarterly. As in past reviews, the monitoring team did their own data collection timeliness by sampling individual data books across several homes, and noting if data were recorded up to the previous two hours for target and replacement behaviors. The target and replacement behaviors sampled for 12 of 24 data sheets reviewed (50%) were completed up to the two previous hours. This result represented a slight decrease from the last review when 58% of the data sheets reviewed by the monitoring team were recorded up to two previous hours. This percentage of timely data collection was also below that collected by the facility (71%), and their data timeliness goal level (80%). It is recommended that LSSLC use performance feedback to improve DSPs data collection timeliness across the facility. 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 their goal level of data IOA to be 80%, and that every PBSP would have IOA measures at least quarterly. They reported that from 1/1/14 to 6/30/14, IOA averaged 93%, and 46% of the individuals with a PBSP had an IOA measure at least quarterly. This level of IOA was above the goal established by LSSLC, however, the frequency was well before that established by the facility. It is recommended that the behavioral health services department ensure that IOA is collected at least quarterly for all individuals with a PBSP. Finally, the monitoring team observed the collection of data collection timeliness and IOA data. The method used appeared to be appropriate. 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.	

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		The routine use of data to make treatment decisions continued to be very good. During the onsite review, both of individuals discussed in psychiatry clinics had current data contributing to data based decisions concerning the use of medications and treatment interventions. In reviewing at least six months of PBSP data of severe behavior (e.g., physical aggression, self-injurious behavior) for the 13 individuals (Individual #287's PBSP was new and only limited data were available to review), eight (Individual #97, Individual #252, Individual #273, Individual #192, Individual #298, Individual #392, Individual #330, and Individual #176), or 62%, indicated clear improvement in severe behavior. This represented another improvement from the last review when 46% of the individual's reviewed showed no obvious improvement in severe behavior. Finally, there were also improvements in the progress notes. The monitoring team consistently found examples of action taken to address the lack of progress (e.g., Individual #129), and the presentation of data collection timeliness, IOA, and treatment integrity data (see K10). 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 ensure that established minimum frequencies and levels of data collection reliability and IOA data are achieved.	
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 320 of the 328 (98%) individuals at LSSLC had a full psychological assessment. This was identical to the last review when 98% of individuals had a full psychological assessment. The spreadsheet also indicated that 40 full psychological assessments were completed in the last six months, and four of those (10%) were reviewed to evaluate their comprehensiveness. As found in the last four 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 195 of the 195 individuals with PBSP (100%) had a functional assessment. One hundred and eighty-three of those functional assessments (94%) were current (i.e., revised/reviewed within one year). This was consistent with the last review when 95% of the functional assessments were	Substantial Compliance

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		current. The spreadsheet also indicated that 89 functional assessments were completed in the last six months. Fourteen of these (16%) were reviewed to assess compliance with this provision item. As discussed in previous reports, the facility used a format combining psychological evaluations, PBSPs, and functional assessments that included all of the components commonly identified as necessary for an effective functional assessment. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect procedures can contribute to understanding why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. As found in the last report, all of the functional assessments reviewed included acceptable indirect assessment procedures. Twelve of the 14 functional assessments reviewed (86%) were judged to contain adequate direct assessment procedures. This represented a decrease from the last review when 100% of direct observation procedures were judged to be acceptable. Individual #392's functional assessment did not include a direct assessment. Individual #59's functional assessment included a discussion of a direct observation, but it did not include any examples of target behaviors and, therefore, did not contribute to a better understanding of the variables affecting her undesired behaviors. All functional assessments should include direct observation procedures that include observation of the target behavior (or an explanation why that was not practical or possible), and provide information about relevant antecedent and/or consequent events affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This is consistent with the last report when all functional assessments included potential antecedents and consequences. Thirteen of the 14 functional assessments reviewed (93%) were judged to have a clear summary statement. This was another decrease from the last review when 100% of the functional assessments reviewed were found to have a clear summary statement. Individual #392's functional assessment did not contain a summary statement.	

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		Overall, 12 of the 14 (Individual #392 and Individual #59 were the exceptions) functional assessments reviewed (86%) were evaluated to be comprehensive and clear. This represented a decrease from the last review when 100% 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.	
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 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 326 of the 328 (99%) full assessments (see K5) were completed in the last five years. This is comparable to the last review when 97% 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 two reviews, annual psychological updates were completed for all individuals at LSSLC, and 326 of 328 (99%) were current. This represented a slight increase from the last review when 94% of annual updates were current. A spreadsheet indicated that 174 annual psychological assessments were completed in the last six months, and 18 (10%) of these were reviewed by monitoring team to assess their comprehensiveness. All 18 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 six individuals admitted to the facility in the last six months had psychological assessments within 30 days of admission.	Substantial Compliance

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		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.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	This item was rated as being in noncompliance because no treatment plans for psychological services other than PBSPs were available for review. A counseling committee was in place for the past two years and a referral and treatment process was established at LSSLC. Since the last review, psychological services other than PBSPs were provided for two individuals. This was similar to the last review when three individuals were provided psychological services other than PBSPs. There were no treatment plans available for these individuals. Over the next six months it is recommended that the facility ensure that the need for psychological services other than PBSPs is documented in each participating individual's ISP or PBSP. Additionally, all psychological services other than PBSPs should contain the following: • A treatment plan that includes an initial analysis of problem or intervention target • A treatment plan that is goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A treatment plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A treatment plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings • Need for the service is documented Finally, the facility needs to document that the staff providing the therapy were qualified, and that individuals that would benefit from these services are receiving it.	Noncompliance

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K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	The quality of the PBSPs at LSSLC continued to be consistently high. Additionally, since the last review, the facility had provided documentation that 82% of PBSPs had been implemented within 14 days of receiving consent. Therefore, this provision item is now judged to be in substantial compliance. A list of individuals with PBSPs indicated that 195 individuals at LSSLC had PBSPs and 183 of these (94%) were current (i.e., reviewed/revised at least every 12 months). This was comparable to the last review when 95% of PBSPs were current. All PBSPs had the necessary consent and approvals. At the time of the onsite review, 67 of 82 PBSPs completed since January 2014 (82%) were implemented within 14 days of receiving consent. This represented a sharp increase compared to the last review when only 25% of PBSPs were implemented within 14 days of receiving consent. Eighty-nine PBSPs were completed since the last review, and 14 (16%) of these were reviewed to evaluate compliance with this provision item. All 14 of the PBSPs reviewed (100%) included operational definitions of target and replacement behaviors. This was an improvement from the last review when 85% of the PBSPs reviewed included operational definitions of target and replacement behaviors. Thirteen of the 14 PBSPs reviewed (93%) described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the stated function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This represented a decrease from the last review when 100% of the PBSPs reviewed were judged to be consistent with the stated function. The consequent intervention potentially incompatible with the hypothesized function was: • Individual #170's PBSP stated that during physical aggression staff should determine if he needs a snack or drink. Providing a snack or drink (identified as reinforcers in his functional assessment) immediately following physical aggression could result in an increase in the target behavior in the future. Anticipating his needs, and providing him with desired items prior to engaging in target behaviors (which was also included in the PBSP), was consistent with his functional assessment. DSP, however, should be directed to avoid providing desired objects during the occurrence of the target behaviors. Replacement or alternative behaviors were included in all (100%) 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 when providing the reinforcer for alternative behavior is practical. The monitoring team found that 14 of 14 (100%) replacement behaviors that could be functional were functional. This was	Substantial Compliance

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		consistent with the last review when 100% of all replacement behaviors that could be functional were functional. 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. As found in the last review, all 14 PBSPs reviewed (100%) included the reinforcement of replacement/alternative behaviors. Overall, 13 (Individual #170 was the exception) of the 14 PBSPs reviewed (93%) represented examples of complete plans that contained all of the following. This represented an improvement from the last review when 85% of the PBSPs reviewed were judged to be acceptable. • rationale/purpose of the plan • operational definitions of target behaviors • operational definitions of functional replacement behavior • behavioral objectives for one or more target behaviors • behavioral objectives for one or more replacement behaviors • use of (if the individual does not have the replacement behavior in his/her repertoire) SAPs to address the acquisition of replacement/alternative behaviors • baseline data for one or more target behavior • antecedent-based or preventative strategies • strategies to promote replacement or alternative behavior • consequence-based strategies (what to do when behavior occurred) • the use of positive reinforcement • descriptions of data collection procedures • signed and dated The behavioral health services department should be commended for their improvements in the timeliness and quality of PBSPs. In order to maintain substantial compliance with this provision item, the facility needs to document that at least 85% of 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	There were improvements in this provision item, however, more work (discussed below) is required before it can be rated as being in substantial compliance. Since the last review, LSSLC developed a database to track the frequency and level of all	Noncompliance

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	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.	behavioral systems (i.e., data collection timeliness, IOA, and treatment integrity) for individuals with a PBSP. The facility established that IOA would be collected once a quarter for every individual with a PBSP and that the level would be at or above 80%. As discussed in K4, LSSLC's IOA data indicated that they achieved their goal level (the average IOA score was 93% for individuals with a PBSP), but did not achieve their goal frequency (only 46% of individuals with a PBSP had IOA measures at least quarterly). 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. The facility established that treatment integrity would be collected quarterly for every individual with a PBSP, and the minimal acceptable level would be 80%. LSSLC data from 1/1/14 to 6/30/14 indicated that they achieved their treatment integrity level goal (the average treatment integrity score was 94%), but did not achieve their treatment integrity treatment goal (only 27% of individuals with a PBSP had at least one treatment integrity measure a quarter). It is recommended that the facility ensure that treatment integrity frequency and level goals are achieved for each individual with a PBSP. 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. 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 in substantial compliance. LSSLC utilized an abbreviated behavior support plan that was located in the individual notebooks, and was written so that DSPs could understand them. The monitoring team reviewed 14 PBSPs written in the last six months and concluded that they all 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 2.4 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 18 PBSPs written in the last six months and determined that they averaged a 9.3 reading level.	Substantial Compliance

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		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.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	This item was rated as being in noncompliance because, at the time of the onsite review, LSSLC did not have documentation that every staff assigned to an individual was trained on his or her PBSP. As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Staff trainings were scheduled twice a week, resulting in many DSPs being trained each month. Behavioral health specialists and behavior analysts conducted the trainings prior to PBSP implementation and whenever plans changed. All DSPs asked about training during the monitoring team's review indicated that they had been trained. The monitoring team did not observe the training of PBSP during this onsite review. In past reviews, however, the monitoring team found the training to be thorough, including a review of the PBSP by the behavior specialist, an opportunity for DSPs to ask questions, and written questions pertinent to the PBSP. The facility maintained inservice logs on all staff training conducted by the behavioral health staff. At the time of the onsite review the majority of float staff were inserviced by the residential staff. Additionally, the behavioral services department did not know the method residential staff used to train these staff. In order to meet the requirements of this provision item, the facility will need to present documentation that every staff assigned to work with an individual, including float/relief staff, has been trained (in a manner similar to that conducted by the behavioral health department) in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA for every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, LSSLC had a census of 328 individuals and employed 15 behavioral health specialists responsible for writing PBSPs. Additionally, the facility employed seven psychology assistants. Three of the facility's behavioral health specialists that wrote PBSPs had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least 11 behavioral health specialists with BCBAs.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 5/15/13 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 21 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders

	○ Listing, Individuals with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD ○ Listing, Individuals hospitalized and sent to emergency department ○ AED Polypharmacy Data ○ 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 #517, Individual #382, Individual #357, Individual #450, Individual #502, Individual #170, Individual #59, Individual #337, Individual #121, Individual #299 ○ Annual Medical Assessments the following individuals: • Individual #134, Individual #336, Individual #101, Individual #137, Individual #58, Individual #152, Individual #190, Individual #453, Individual #114, Individual #88, Individual #562, Individual #223, Individual #503, Individual #447, Individual #598 ○ Neurology Notes for the following individuals: • Individual #308, Individual #597, Individual #539, Individual #500, Individual #521, Individual #401, Individual #542, Individual #318, Individual #304, Individual #428 <u>Interviews and Meetings Held</u>: ○ Ronald Corley, MD, Medial Director ○ Andra Self, Clinical Services Director ○ Verena Hug, MD, Primary Care Provider ○ Michael Riggs, MD, Primary Care Provider ○ Toni McDonald, RN, MSN FNP-C ○ Tammy Nelson, LVN, Medical Compliance Coordinator ○ Judd Williamson, RN, Psychiatry Nurse Supervisor ○ Mary Bowers, RN, Chief Nurse Executive ○ Paul Vann, RN, QA Nurse ○ Gale Wasson, Facility Director <u>Observations Conducted</u>: ○ Daily Clinical Services Meetings ○ Medication Variance Meeting ○ Polypharmacy Committee Meeting ○ Pharmacy and Therapeutics Committee Meeting ○ Pneumonia Review Committee ○ 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) the provision action information. The clinical services director served as the lead for this provision. For each provision item, the clinical services director 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. There was great improvement in the self-assessment. It reviewed many of the same items reviewed by the monitoring team. For section L1, preventive care data, AMA assessment data, and ISP participation were all reviewed. Notwithstanding these improvements, the self-assessment, at times, did not utilize the most valid metrics. Additionally, preventive care data were presented in a manner that resulted in factitiously increased compliance rates. For future self-assessments, the clinical services director will need to include more of the metrics utilized by the monitoring team. 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 provision L1, L2 and L3. Provision L4 was rated as substantial compliance. The monitoring team found all four provisions to be in noncompliance.
	Summary of Monitor's Assessment: The medical department of LSSLC continued to face many challenges. There was a series of staffing changes with the retirement of the lead physician and one long-term staff physician. A new medical director was appointed in June 2014. He had worked at the facility for a number of years. The role of medical director was broad and he was learning all that it entailed. Facility staff responded well to his direction and expressed appreciation for the work that he was doing. The two staff positions were filled with locum tenens providers at the time of the compliance review. Physician participation in the annual ISPs increased, although the exact number of meetings attended was not clear. Physicians participated in some meetings by phone. There were a substantial number of changes implemented since the January 2014 compliance review. The facility was utilizing the services of an advanced practice registered nurse to complete pelvic exams and cervical cancer screenings. Preventive care data were being tracked by the medical department in an ongoing manner. This was effective in increasing the number of individuals who received preventive care services, such as cancer screenings. Compliance with breast cancer screenings increased and compliance with colorectal cancer screening remained high.

	The full time medical staff improved compliance with completion of Quarterly Medical Summaries. Improvement was also seen in the completion of the Preventive Care Flow sheets and updating of the Active Problem Lists. The facility addressed problems with the availability of the consultation IPN forms and this resulted in improved documentation in the IPN of consultations. The positive findings of this review were, to some extent, negated by a host of problems identified by the monitoring team. Several workgroups were created to address issues, such as pressure ulcers and pneumonia management. The impact of those efforts had yet to be realized because individuals continued to experience poor outcomes, such as bowel obstruction, ileus, recurrent pneumonia and stage III and stage IV pressure ulcers. Nephrolithiasis appeared to be a source of morbidity. The actual prevalence was not known, but an unusual number of individuals were noted to have kidney stones. Several of these individuals were treated with topiramate. It was disconcerting to find that this association had not been detected, particularly because the use of topiramate and the propensity to cause metabolic acidosis was highlighted in section N of the last monitoring report. There was an abundance of evidence that physician notification of illness was a major concern at LSSLC. The majority of the records reviewed provided documentary evidence that physicians were not being notified of acute medical problems. Facility management was aware of this because the daily meeting minutes often included examples of communication that should have occurred with the physicians, but did not. Assessing the physician response to acute medical problems was sometimes difficult because of a lack of documentation. Based on IPN documentation, it appeared that the physicians often did not respond to acute issues. However, physician orders frequently indicated that treatments and care were being provided. The physician's role in care is difficult to asses in the absence of documentation. Documentation surrounding transfer to acute care facilities was consistently poor for most, but not all, providers. The facility conducted internal and external reviews as required, and implemented corrective actions. Progress was seen with the development of the medical quality program. The quality program requires revision and continued work, but the facility made good progress by defining indicators, developing tools, and conducting audits. With implementation of the audits, the medical department now had several key components of a medical quality program. A number of policies and procedures were developed and/or revised. The facility will need to devote some time to ensuring that the policies procedures and guidelines are consistent with state policy and the prevailing standards of care. Several inconsistencies in standards were identified in policies, procedures, and audit tools. Assessing this area was difficult because some documents provided no indication of the dates of implementation or revision. However, it was clear that several were outdated and required review.

	Finally, data provided to the monitoring team documented that for the period of September 2013 to June 2014, LSSLC had the highest number of ER visits with admission of the 13 SSLCs and LSSLC had the second highest number of total hospital admissions. High rates of hospitalization may signal quality problems and require further analysis.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents; facility reported data, staff interviews, and observations. Records were selected from the various listings included in the 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** There were several changes within the medical staff since the January 2014 compliance review. The lead physician retired in January 2014. One of the two long-term physicians assumed the role of the medical director. The second long-term physician retired the week prior to the compliance review. Two locum tenens primary care physicians began working at the facility on 7/1/14. A second advanced practice registered nurse was also working as a locums practitioner. At the time of the compliance review, there was a full time medical director, two full time locum tenens primary care physicians and two APRNs. Each primary care provider was assigned a licensed vocational nurse to provide additional support. The average caseload for the physicians was 86. The APRN's caseload was 74. The agreement between the full time facility employed APRN and physicians was current. Although the locums APRN was noted to have worked intermittently at the facility since 2012, there was no agreement signed by her and the collaborating physicians. The medical department had an adequate number of primary care providers working, but the actual number of hours available for direct care was not clear. The medical director continued to manage employee injuries. Moreover, the daily medical meeting notes often documented the absence of medical staff members, frequently noting that they were not at the facility that day. The facility must ensure that an adequate number of primary care providers are actually present and working. There should be guidelines regarding medical staff leave to ensure that staffing is adequate on a daily basis. The clinical services director, who was hired in March 2013 to provide administrative oversight for the medical, pharmacy, psychiatry, and dental departments, continued in	Noncompliance

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		that role. She appeared to be an integral factor in the management of health care services at the facility. As noted in the previous monitoring report, the medical compliance nurse position at LSSLC was filled by an LVN. The position was now known as the medical compliance coordinator. It was not clear why the facility elected not to have a registered nurse serving in that role as typically seen at other SSLCs. **Physician Participation In Team Process** <u>Daily Clinical Services Meeting</u> The facility continued its daily clinical services meeting. The medical director facilitated this meeting, which was attended by all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, habilitation staff, and psychology. 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. Pressure ulcers were discussed weekly as well. The minutes reviewed by the monitoring team provided detailed information related to hospitalizations, campus calls, clinic appointments, and other issues. Documentation of follow-up to the discussions was much improved. The clinical services director appeared to be instrumental in the review of follow-up issues. The monitoring team continued to observe that clinical curiosity was lacking. Staff failed to ask many questions that should have been asked. When abnormal findings were presented, no one questioned the contributory factors. One member of the nursing staff reported that a lack of questions during meetings was due to the presence of the monitoring team. However, documentation in records and meeting minutes indicated that a lack of clinical curiosity was not atypical. Staff tended to accept the "status quo." It will take strong clinical leadership to reverse this pattern. Staff will need to develop a practice of questioning why events occurred. The participation of the PCPs and key clinical staff made the daily meeting an optimum forum for such dialogue. <u>ISP Meetings</u> The monitoring team requested documentation of PCP attendance at the annual ISP meetings. Data for the months of January 2014 through June 2014 were submitted and are summarized in the table below. Primary Care Provider ISP Attendance 2014 | | No. of ISPs | Meetings Attended | Meetings Attended (%) | | Jan | 29 | 10 | 34 | | Feb | 28 | 4 | 14 | | Mar | 27 | 7 | 26 |	

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Apr	27	7	26
May	24	1	4
Jun	33	10	30
Total	168	39	23

The PCPs attended 23% of all annual ISPs conducted during the reporting period. This was an overall increase in participation. The data submitted represented meetings attended by the PCPs as well as those where the PCPs participated by phone. Documentation in meeting minutes revealed that the medical department continued to focus on attendance at the "required meetings." It also appeared that it was considered acceptable, but not preferable, for LVNs to attend. The monitoring team encourages both the PCPs and LVNs to attend meetings. However, PCP compliance data should only include those meetings where the PCP attended. Phone consultations for ISPs should be noted separately.

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 at two community hospitals 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. Bone radiographs were read by the medical director who was a board certified orthopedic surgeon. EKGs were not routinely over-read by a cardiologist. The clinical services director reported that only abnormal EKGs were referred to cardiology. The facility should address this, because all EKGs should have a final reading by a cardiologist.

There were modest improvements in some elements of preventive care. Cancer screenings were increasing and the Zoster vaccination was being provided to individuals over the age of 60 years. Improvement was noted in the overall completion of Quarterly Medical Assessments and updating of the APLs.

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		While many basic health needs of individuals were met, there was evidence that improvement was needed in many areas. Gaps in care were identified in a number of areas: • Physicians were frequently not notified of medical concerns. This was seen in several of the records reviewed. Meeting minutes pointed out additional instances in which there was a failure to notify the medical staff of acute conditions. Even when the primary providers were notified, it was difficult at times to measure their response because documentation of acute medical assessments was often not found in the records. • Documentation of acute medical conditions was often incomplete. Physician documentation of problem resolution was infrequent. Similarly, the active records sometimes lacked or included inadequate documentation of pre-hospital transfers and post-hospital assessments. Some individuals returned to the facility for a few days and were re-admitted to the hospital without having any documentation of physician assessment after the initial hospitalization. • Several individuals had recurrent pneumonia and there was little evidence that proper consideration was given to the interventions that needed to be implemented to minimize risk and recurrence. The medical staff rarely documented what, if anything, would be done to minimize risk. • Bowel management continued to present challenges. The facility did not have aggregate data on acute interventions, such as enema and suppository use, but during the daily morning meetings, the monitoring team heard reports of numerous individuals who required suppositories and enemas for management of constipation. There were many hospital admissions related to ileus and several individuals experienced poor outcomes. • A significant number of individuals continued to develop pressure ulcers even though a number of preventive measures were reported to be implemented. Unfortunately, Stage III and Stage IV pressure ulcers continued to be discovered at the time of the compliance review. • Medication monitoring needed improvement. The January 2014 monitoring report discussed deficiencies related to medication monitoring, particularly for the use of atypical psychotropics, antihypertensives, and topiramate. More specifically, eye examinations were not completed as required for the use of quetiapine and topiramate. There was a need to implement appropriate monitoring for metabolic acidosis for individuals who received topiramate because the lab matrix indicated monitoring was done as clinically indicated. EKG monitoring was also documented to be problematic. Monitoring for metabolic syndrome also needed improvement. Many of the same issues were seen in this review. In fact, the monitoring and detection of metabolic syndrome proved to be increasingly challenging at LSSLC.	

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		The subsequent sections of this report will discuss details related to these issues and provide specific examples. **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 • 7 of 10 (70%) 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: • 11 of 15 (73%) 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 Overall, there was little improvement in the quality of the AMAs. Documentation of preventive health services, family, and social histories improved. Even so, the majority of AMAs failed to link key elements and provide a robust medical plan for the active problems. Consults, sick call visits, and diagnostics were listed without utilizing this information to synthesize a cogent plan of care for active medical problems. Some AMAs failed to demonstrate the association between problems such as GERD, aspiration, and pneumonia.	

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		The following are some of the other concerns observed in the record sample and facility submitted sample of AMAs: • The facility submitted a sample of 15 AMAs, none of which were signed or dated by the providers. Since the delay between completion of assessments and the final signing was a concern during the last review, it was problematic that the facility clearly chose to submit a sample that did not allow for any assessment of this issue. • Providers were required to use the state template. However, it appeared that little thought went into the content of the assessments. For example, multiple assessments included labs that appeared to be copied and pasted from the actual lab reports. The laboratory's information on FDA approval, testing sites, etc. was all included and pasted into the AMAs. Thus, four or five lab results spanned across 10 pages of some AMAs. Entire consults were also cut and pasted into some evaluations. This practice provided little value and ultimately diminished the usefulness of the assessments. The medical compliance coordinator reported that the medical LVNs assisted the PCPs by filling in some components of the assessment template. • The plans of care in many of the AMAs were not adequate. Providers continued to write plans, such as "follow-up with GI" or "continue G-tube feeds." As was seen in many aspects of this review, the quality of the AMAs varied greatly by provider. While most were disjointed and failed to provide a snapshot of the individual's health status, as noted in previous reviews, one provider continued to generate assessments that were thorough and provided good information about the health status of the individuals. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were being completed as required by the Health Care Guidelines by <u>some medical providers</u>. For the records contained in the record sample: • 8 of 10 (80%) records included a current QMS The QMSs were completed 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. Completion of QMSs and the content was very provider specific. It was noted that the locum tenens provider did not appear to complete any Quarterly Medical Summaries.	

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		Active Problem List 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. Most APLs had some degree of updates. This was an improvement from previous reviews. Integrated Progress Notes 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 continued to be a significant concern with several providers. As noted in previous compliance reviews, problems with IPN documentation were not limited to legibility. The content of IPN documentation frequently did not comply with the requirement to document the pertinent positive and negative findings for evaluations of acute conditions. An overwhelming number of entries related to acute conditions never indicated resolution of the problem. That is, the PCP did an assessment, documented in the IPN, but never documented any follow-up assessment of the individual. It was difficult to determine if any follow-up occurred apart from that done by nursing staff. State medical policy provided clear guidelines on the requirements for documentation in the IPN. For acute medical problems, a number of documentation elements were required, including (1) documentation of pertinent positive and negative exam findings, (2) a plan for future evaluation, treatment and monitoring, and (3) documentation of follow-up assessments at a frequency consistent with the individual's status and presenting problem until the problem was resolved or stabilized. Daily monitoring was required for any serious acute illness until the individual was stable or the illness resolved. Documentation related to hospitalizations and ER transfers was inconsistent. Documentation by the PCP prior to hospital transfer was frequently not located in the records. Nursing documentation often stated that the PCP gave an order to transfer the individual, but there was no documentation of a primary care provider assessment. Thus, there was no documentary evidence that the PCP conducted an assessment even during normal work hours and there was no documentation that the PCPs communicated with accepting hospital physicians. Per state medical policy, "Upon determining that an individual requires off-campus medical emergency care, the PCP must attempt to communicate with the receiving hospital emergency room or admitting physician. This requires direct contact with hospital staff. The PCP documents this contact and the information discussed in the IPN. If the PCP was unable to assess before transfer, he or she must provide within one business day of transfer a summary of	

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		events leading up to the acute event and the disposition." Physician compliance with post-hospital assessments was also deficient. Several records documented one assessment following hospital return, but other records lacked any documentation of post hospital assessment or included an initial assessment that occurred several days after the individual returned to the facility. Medical policy needs to explicitly address these issues. The facility is required to provide medical coverage on a 24-hour basis. The requirement to have medical follow-up within 24 hours of return to LSSLC is not suspended on weekends or holidays. <u>Physician Orders</u> 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. Orders were written for extended release (non-crushable) medications to be given through enteral tubes. As noted in the previous review, physician orders were frequently noted for treatments in the absence of documentation of an appropriate evaluation. Medication orders are discussed further in section N1. <u>Consultation Referrals</u> 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. A template was used for IPN documentation. Generally, there was significant improvement in IPN documentation. However, in many instances, there appeared to be delays greater than five days between the date of receipt and date of documentation in the IPN. Consultation referrals are discussed in further detail 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 more difficult to verify.	

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		Compliance with colorectal and prostate cancer screening remained high. Compliance with breast cancer screening continued to improve. Females were having gynecological examinations, but it was difficult to determine who actually completed cervical cancer screening. 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: • 10 of 10 (100%) records included PCFSs The Preventive Care Flow sheets were found in 100% of the records reviewed. Most appeared to have been updated. The medical LVNs assigned to each PCP completed these documents, signed and dated the documents at the time of updating <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 The facility submitted the immunization database at the request of the monitoring team. A number of individuals were noted to have outstanding consent for some of the core vaccinations, such as hepatitis B and varicella. There were also several individuals that were not vaccinated against varicella and did not have antibody documentation of immunity based on date of birth. The CDC does indicate that individuals born before 1980 can be considered immune to varicella. However, it is incorrect to apply this standard in a long-term care facility. Specific recommendations are made for health care professionals, residents, and staff in nursing homes and residential settings. The varicella vaccination is recommended for those individuals. The monitoring team discussed the use of the federally required Vaccine Information Statements with the medical director, clinical services director, and medical compliance coordinator. State policy indicated that informed consent was to be obtained for all immunizations. However, medical policy did not explicitly state the requirement for provision of the VIS or the documentation of the VIS. The National Childhood Vaccine Injury Act requires that all health care providers in the US, who administer to any child or adult certain vaccinations such as, but not limited to, varicella, tetanus, influenza, and hepatitis B, provide prior to administration of each dose, a copy of the "relevant current edition VIS produced by the CDC." Health care providers are also required by this federal	

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		law to "make a notation in each patient's permanent medical record at the time vaccine information materials are provided" the version of the VIS and the date provided. This is a requirement in addition to noting the vaccine manufacturer and name of the person administering the vaccine. The medical compliance coordinator reported to the monitoring team that the VISs were provided, but the permanent records did not include the required documentation. Screenings • 8 of 10 (80%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing Data provided by the medical department included several individuals that did not have the most recent eye evaluations listed. Prostate Cancer Screening • 3 of 8 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 submitted. The total for both lists was 117 males: • 111 of 117 (95%) males had current PSA screening The documentation of explanations for a lack of PSA testing indicated that one PCP did not perform PSA testing based on the recommendations of the USPTF. The facility did not follow USPTF guidelines for PSA testing. According to the facility's preventive care guidelines, providers were to continue to "perform a PSA every year for African American men and men with a family history of prostate cancer between the ages of 45-75." The American Cancer Society recommends that starting at age 50, or 45 if high risk, men should discuss the pros and cons of testing with their physician, so that they can make an informed decision with their health care provider about screening for prostate cancer. High-risk groups include African Americans and men who have a first-degree relative diagnosed with cancer before the age of 65. Most major professional organizations have issued similar statements. Thus, providers should consider the discussion with the individual/LAR when making a decision to defer testing. Breast Cancer Screening • 1 of 2 females met criteria for breast cancer screening • 0 of 1 (0%) females had current screenings	

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		The monitoring team requested a list of females age 40 and older. A list of females age 40-69 was provided. The list included the names of 103 females, the date of the last mammogram, and explanations for any lack of testing: • 89 of 103 (86%) females had current screenings • Of these 14 of 103 (14%) females: o 5 of 103 (5%) females no reason o 4 of 103 (4%) females did not have mammograms due to guardian refusal o 2 of 103 (2%) had scheduled mammograms o 3 of 103 (3 %) other reasons The LSSLC preventive care guidelines were updated in May 2014 and the policy highlighted that LSSLC utilized the American Cancer Society guidelines. The policy further indicated that mammography would begin at age 40 and occur every one to two years. The facility had a cut-point of 70 years since all documents submitted included women up to the age of 69. The guidelines, as written in facility policy, were not consistent with the ACS guidelines. Per the ACS, "Yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health." The USPTS recommends mammograms until the age of 74 years. Cervical Cancer Screening • 0 of 2 females met criteria for cervical cancer screening A list of females age 21 and older was provided. The list included the names of 116 females, the date of the last pap smear, and explanations for any lack of testing: • 65 of 116 (56%) females had cervical cancer screening within three years o 32 of 116 (27%) females had imperforate hymens o 6 of 116 (5%) females were uncooperative o 3 of 116 (2) females had total hysterectomies o 6 of 116 (5%) females had no reasons for lack of screening o 2 of 116 (2) females had screening deferred o 2 of 116 (2%) female had screening scheduled The facility reported 92% compliance with cervical cancer screening. The July 2014 QA report noted that 102 well woman exams (WWE) were completed as of June 2014. The data further documented the number of WWEs and pap smears done from December 2013 to June 2014. For each month, the number of WWEs was equal to the number of pap smears. This was an incorrect presentation of the data. Approximately 30% of females who had exams did not have cervical cancer screening (pap smear). For a	

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		sample of 10 women in which WWEs were performed in April 2014 and May 2014, 9 females were reported to have cervical cancer screening. The monitoring team requested the reports for these females. However, the facility submitted only <u>one cytology report</u> as requested. That screening was done by a community provider. No explanation was provided for the lack of the reports associated with the pap smears that were reported to have been done on campus. Two other findings are worthy of discussion. The first is that documentation in the consults reviewed by the monitoring team indicated that two individuals were referred to the local gynecologist for evaluation of cervical polyps, but the consultant found no evidence of cervical polyps on examination. This discrepancy in findings should be addressed. The second issue is that of risk assessment. The gyn consultation forms documented that many women were considered "low risk." This risk determination was made when the individual's family and gynecological history was stated to be unknown. The risk for cervical cancer may be low due to a low probability of infection with human papilloma virus. However, there may be continued risk for other gynecological problems. <u>Colorectal Cancer Screening</u> • 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 202 individuals: • 195 of 202 (97%) individuals had completed colonoscopies • 2 of 202 (4%) individuals had orders pending for evaluation • 1 of 202 (3%) individuals had no explanation for lack of testing • 1 of 202 (1%) individuals had or prep • 3 of 202 (1%) consent Two of the individuals noted to have colonoscopies completed had dates listed that were after the document request was submitted. Those dates should have been noted as scheduled. **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.	

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		Pneumonia The facility submitted a list of individuals who were diagnosed with pneumonia from June 2013 through June 2014. Data for that period are shown in the table below.	

Pneumonia 2014						
	Jan	Feb	Mar	Apr	May	Jun
Aspiration	0	2	2	0	1	1
Bacterial	5	8	7	9	4	4
Viral	1	0	0	0	0	0
Total	6	10	9	9	5	5

The AVATAR tracking forms were requested. The monitoring team received a list of individuals with pneumonia. Information documented included the type of pneumonia, feeding route, feeding method, and food texture. The data provided no information related to the CXR findings and immunization status. There was also no information, such as complete blood counts and culture results.

The facility reported data showed that recurrent pneumonia was problematic. During fiscal year 2013, 17 individuals had more than two cases of pneumonia for a total of 40 events. For fiscal year 2014, 15 individuals had multiple pneumonia episodes for a total of 33 events as of 5/31/14. The hospital reports and daily clinical meetings minutes documented many individuals with a diagnosis of pneumonia. Based on the data above, only a small percentage of those were confirmed/reported as pneumonia. The facility had only recently implemented a process to review and confirm data, so the accuracy of the reported pneumonia data was questionable. Nonetheless, the incidence of pneumonia was increasing. Forty-five cases of pneumonia were reported in FY2012, 88 in FY2013, and 66 in FY2014.

Since the last compliance review, the facility formed a Pneumonia Review Committee. The monitoring team attended the committee meeting, which was conducted the week of the compliance review. The participants reviewed the pneumonia checklist/tool and agreed that the diagnosis was aspiration pneumonia for Individual #361. Unfortunately, that appeared to be the typical focus of the discussion. The group needed prompting from the monitoring team to move forward with a discussion on the factors contributing to aspiration and how those could be minimized.

Documentation in the records did not support that the IDT or PCP had considered the next course of action or discussed the etiology of the aspiration - seizure, aspiration of gastric contents, or aspiration of upper airway secretions. Oral hygiene was considered and suction toothbrushing was usually provided. Continued management requires a thoughtful discussion of many factors in order to take the next most appropriate actions. Medical meeting minutes documented that a locum tenens physician inquired about

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		using a gastric jejunal tube for an individual who possibly aspirated enteral feedings. A staff physician responded that "we have no luck" with those and, therefore, a change in the type of tube was not considered. While the use of gastric-jejunal tubes has some disadvantages, they are indicated in the face of recurrent aspiration of gastric contents. The use of the jejunal tubes should not be dismissed solely based on the facility's history. Rather, the facility should determine if staff training played a role in the failures associated with use of the jejunal and gastric-jejunal tubes. The facility had a great deal of work to do in order to improve the pneumonia review process as well as the overall management of pneumonia, specifically management of recurrent aspiration. This should be considered a priority for staff due to of the morbidity and mortality associated with aspiration. Documents reviewed showed that in recent months, at least two individuals experienced respiratory and/or cardiac arrest and required intubation and mechanical ventilation because of aspiration (Individual #202 and Individual #357). Other individuals were developing chronic and irreversible pulmonary changes due to recurrent aspiration. The CNE who chaired the committee stated that aggregate pneumonia data would be discussed in the Infection Control Committee. This would appear to be appropriate. It was also be appropriate for this committee to be chaired by someone other than the CNE. The medical director and infection control nurse should be considered for this role. <u>Osteoporosis</u> A list of all individuals with osteoporosis and osteopenia was provided. The list included 255 names: • 130 individuals were diagnosed with osteoporosis o 120 of 130 (92%) individuals received pharmacologic therapy o 110 of 130 (85%) of individuals had current DEXA scans The facility considered a DEXA scan current if done within the past three years. The International Society for Clinical Densitometry, the National Osteoporosis Foundation, and the American Association of Clinical Endocrinologists all had recommendations for followed up BMDs to be done within one to two years of starting or changing therapy. Thus, the three-year guideline was not consistent with the recommendations of the major professional organizations. LSSLC did not provide comprehensive data for osteoporosis management. Data were limited to the timeliness of obtaining bone mineral density studies. The facility presented a DUE on osteoporosis in April 2014. The DUE report simply indicated the number of individuals receiving the various osteoporosis drugs alone and in	

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		combination with PPIs and antacids. The report did not look at the overall management of osteoporosis, such as the appropriateness of medical management. The facility implemented chart audits for management of osteoporosis in April 2014. The tools covered many of the performance measures proposed by several major professional organizations. The frequency of BMD testing, however, was less than that recommended since two years is a common and practical standard. Audits for the three months resulted in the review of 13 individuals. Given the number of individuals with the diagnosis, a more efficient means of obtaining aggregate data related to osteoporosis management is needed. <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. It is highly recommended that the facility develop guidelines for management of hypertension based on the 2014 JNC 8 guidelines. Those guidelines provide a very specific algorithmic approach to the management of hypertension based on a number of factors. Those indicators should be included in the hypertension audits. <u>Diabetes Mellitus</u> Audits for diabetes management were also implemented as part of the medical quality program. Based on record and document reviews, there were several individuals who potentially had the diagnosis of metabolic syndrome. The QDRRs did not adequately identify those individuals and key data, such as glucose levels and abdominal girths were not documented. The medical compliance nurse reported verbally that eight individuals were diagnosed with metabolic syndrome. According to the CDC, both the crude and age-adjusted estimates indicate that approximately 34% of the population 20 years of age and over meets the criteria for metabolic syndrome. Given the high-risk medications utilized at the facility, it is unlikely that only 2% of the facility's population would have the diagnosis. QDRRs and the active records identified several individuals with abnormal HbA1c levels, but who did not reach the cutpoint to be diagnosed with diabetes mellitus. According to the American Diabetes Association, "it is reasonable to consider an A1C range of 5.7–6.4% as identifying individuals with prediabetes." Prediabetes is the term used for individuals who have a relatively high risk for the future development of diabetes. Appropriate interventions at this stage have the ability to decrease the likelihood that an individual will subsequently develop diabetes. It is, therefore, important that these individuals are identified so that aggressive interventions may be implemented. See section N3 for additional discussion.	

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		Constipation Problems persisted in the area of bowel management. As noted in the last compliance review, 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. The facility reported the use of enemas during the daily unit meetings. However, data were not tracked aggregately and reviewed by the medical team. During the daily medical meeting, the monitoring team heard reports of numerous individuals requiring enemas due to constipation. When questioned about this, the facility director reported that she had also noticed an increase in use and association with seizures and with vomiting. Yet, the facility had not done any further exploration of this observation. This was disconcerting because reports indicated that several individuals who had aspiration were known to have emesis and associated fecal impactions and there were numerous hospitalizations associated with the diagnosis of ileus. Daily medical meeting minutes noted that Individual #101 was doing "OK" with the use of daily suppositories. It appeared that the facility staff did not view the use of suppositories and enemas as rescue measures or as an indication that the bowel management plans were ineffective and needed to be altered. It also appeared that documentation in bowel records was problematic. For example, the PCP for Individual #517 noted the bowel movements were reported as N/A for more than 10 days. When this was noticed, an attempt to provide an enema was made, but the individual refused. The PCP noted there was no signs or symptoms of constipation and no further attempts to administer the enema were made. The individual was ambulatory. How or why it took 10 days to determine the lack of accurate documentation was not clear. Documents reviewed by the monitoring team revealed poor outcomes associated with constipation for two individuals. The daily medical meeting minutes documented that Individual #527 had a perforated bowel. A staff physician reported that the diagnosis of perforated bowel was incorrect and the individual had a pneumoperitoneum. By definition, pneumoperitoneum is gas within the peritoneal cavity that represents the harbinger of a critical illness, as gas is present due to the disruption of a hollow viscous organ. In the absence of surgery, peritoneal dialysis, or mechanical ventilation, the presence of gas signifies the rupture of a hollow viscous, organ such as the colon or stomach. This finding should not be downplayed and the occurrence of a bowel perforation resulting in colectomy should have resulted in a critical review of the events leading up to this very serious negative outcome. The records for Individual #517 documented that this individual also experienced a bowel obstruction and volvulus associated with severe constipation. The individual's bowel was successfully	

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		decompressed with endoscopy. Nephrolithiasis On the second day of the compliance review, a facility RN brought forth concerns to the monitoring team about the incidence of kidney stones. The staff member reported, "we have a problem with kidney stones." During the following daily medical meeting, the hospital report included discussion of an individual admitted to the intensive care unit of the local hospital with aspiration and fecal impaction. During the conduct of the discussion, it was reported that the individual had renal stones. It was later determined that the individual received Topamax. Over the next two days, the monitoring team learned, through routine discussion in various meetings, of four additional individuals with a diagnosis of kidney stones. All of these individuals received treatment with topiramate. Four of the individuals in the record sample had a history of nephrolithiasis and all received topiramate. These individuals were being reviewed for reasons other than having kidney stones. A sample of the daily medical meeting minutes for April 2014, May 2014, and June 2014 documented four additional individuals with renal stones, one of whom received topiramate. The manufacturer's package insert stated that adults exposed to topiramate during adjunctive therapy had an incidence of kidney stones two to four times greater than expected in a similar untreated population. The concomitant use of Topamax with any other drug producing metabolic acidosis, or potentially in patients on a ketogenic diet, may create a physiologic environment that increased the risk of kidney stones. The use of Topamax should be avoided in such individuals as well as those with a history of kidney stones. The only absolute contraindication is an allergy to the drug. The facility had not detected a trend in kidney stones nor made any association between the use of Topamax and kidney stones. Given the complexity of the medication regimens and the risk of metabolic acidosis, the facility must address this concern. This issue was discussed in detail in section N2 of the monitoring report for the January 2014 compliance review. The medical staff must be aware of the side effects of frequently used high-risk medications and implement appropriate strategies to mitigate risk and monitor for adverse outcomes. Moreover, the medical staff should be cognizant of the increased risk of adverse outcomes due to the multiple medications prescribed to the individuals. Pressure Ulcers The facility had taken a number of steps to address the management of pressure ulcers. A wound clinic was started with a certified wound nurse. The skin integrity policy was revised and pressure ulcers were discussed weekly in the daily medical meeting. Even so, the findings related to the incidence and prevalence of pressure ulcers was troubling	

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		because a number of individuals had pressure ulcers discovered at Stage III. During the week of the compliance review, Individual #556 was reported to have a new Stage IV pressure ulcer. The prevalence of pressure ulcers is an important quality indicator. Discovery of stage III and stage IV pressure ulcers is a serious incident. Professional organizations, such as The National Pressure Ulcer Advisory Panel recommend that ulcers discovered at stage III and stage IV result in a utilization of processes, such as Root Cause Analysis to (1) determine and gain insight into the development of pressure ulcers through a review of timelines of the event, (2) discover gaps in care, (3) determine compliance with facility protocols, and (4) review the facility's skin management protocols. While the facility had policies related to pressure ulcers, the medical department did not have a formal policy or guidelines to provide direction to the medical staff on pressure ulcer management. Equally or even more important than therapy guidelines is the physician's role in identifying individuals at risk and ensuring that appropriate measures are implemented. Medical policy related to pressure ulcers should include guidance on: • Risk assessment • Positioning needs and pressure reduction • Nutrition and assessment of nutritional status • Pressure ulcer evaluation including wound depth and staging • Management of necrotic tissue and full thickness wounds • Pressure ulcer culture and debridement • Management of infection and ruling out osteomyelitis The medical staff should be intimately involved in the management of care. Given the documentation found in the various meeting minutes of individuals with one or more pressure ulcers, it is imperative that the medical staff provides the proper guidance on clinical management. **Case Examples** Individual #502 • Nursing IPN documentation indicated that, on 7/14/14, this individual had a seizure. The individual's blood pressure was low and the temperature was 93.5. The abdomen was reported to be hard to touch and bowel sounds were hypoactive. The individual had refused meals and snacks. A warming blanket was applied to the individual, but there was no documentation of physician notification of a change in status. At 7:40 pm, it was noted that the hypothermia protocol was implemented. The nursing IPN entry dated 7/15/14, 6:00 am (for	

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		12:20 am), documented the individual's assessment as hypothermia, respiratory distress, and possible fecal impaction. The individual was lethargic with shallow respirations and had a rectal temperature of 93.5. A soaps suds enema was administered. A series of late entry notes documented no improvement in status, but again there was no notification of the on-call physician until 6:40 am. The IPN documented that an order was given to use the Bair Hugger to increase the body temperature. The individual's condition worsened and around 7:45 am, the decision was made to transport the individual to an acute care facility for evaluation. • The individual was admitted to the Intensive Care Unit with the diagnoses of aspiration and fecal impaction. Vasopressors were required, reportedly due to bradycardia and not to maintain an adequate blood pressure. An IPN entry on 7/16/14 noted that the hospital was requesting a DNR. • This individual also received Topamax even though kidney stones were documented in 2013. There was a delay in transporting this individual to an acute care facility. The PCP should have been notified when the hypothermia was discovered because hypothermia may be seen in a number of serious illnesses, such as sepsis. Moreover, there was a series of assessments that documented the deterioration in this individual's status, but there was no notification of the PCP for more than 12 hours. It was also observed that the documentation of events in the IPN was not sequential and the majority of documentation was entered as significantly late entries. There was no physician summary of the events as required by the health care guidelines. Individual #382 • On 6/30/14, nursing reported that the individual had yellow eye discharge. The PCP saw the individual on 7/1/14 and documented a normal exam. Vital signs and temperature were not recorded. The individual was refusing medications. On 7/2/14, the individual continued to refuse meals and medications and was noted to appear dehydrated. Laboratory studies obtained showed a sodium of 153 and a BUN of 51, which was consistent with volume depletion. The individual was transferred to the hospital and received IV fluids in the emergency department. Upon return to the facility, the individual was admitted to the infirmary. The PCP provided appropriate documentation of the individual's status following hospitalization. • On 3/19/14, the individual was assessed by the PCP and was found to have an abscess and cellulitis, most likely MRSA. The IPN notation did not contain information critical to documenting such infections, such as the presence or absence of fluctuance and dimensions of the abscess. This was necessary for	

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		determining improvement or worsening of the condition. However, the record did not provide any documentation of physician follow-up or resolution of this acute condition. Individual #357 • This individual had a history of intractable epilepsy. The plan of care included in the AMA was generally inadequate. For example, the plan for constipation was to "continue bowel regimen" and the plan for tachycardia was to follow-up with cardiology. While little attention was devoted to the plans of care, the lab values for this individual spanned multiple pages because the entire lab report was cut and pasted into the AMA. The complete audiology consult was also inserted in the assessment. This individual had a history of recurrent pneumonia and was hospitalized in February 2014 with respiratory failure that required intubation and mechanical ventilation. This important piece of medical history was omitted from the AMA. Even more important was the finding that recurrent pneumonia was not listed as a problem. Therefore, the PCP provided no plan of care to address this serious problem. • The individual was seen by a consulting epileptologist in 2012 that recommended that the individual have a workup for VNS implantation and return to clinic in four months. The individual was seen in December 2012 by a second epileptologist. There was no discussion of VNS implantation. • Documentation of post hospital follow-up was generally poor. The individual was sent to the emergency department on 4/3/14 for evaluation of abdominal distention. The PCP documented on 4/4/14 that the individual would be given soap suds enemas. There was no discussion of changing the bowel regimen, which appeared ineffective. The next PCP documentation was on 4/8/14. At that time, the individual was noted to be lethargic, was transferred to an acute care facility, admitted with sepsis and Dilantin toxicity, and was discharged on 4/18/14. There was no primary provider documentation until 4/25/14. At that time, the PCP addressed bilateral conjunctivitis. • The individual was transferred to the emergency department again on 5/15/14 due to hypoxia and was admitted with pneumonia and sepsis. The individual was discharged from the hospital on 5/22/14. However, the first PCP assessment in the IPN notes was dated 5/26/14. The PCP documented that the individual was admitted with pneumonia. The physician did not address the history of recurrent pneumonia or provide any indication of what changes would be made to the individual's plan or medical management. There was no additional PCP documentation. • On 6/5/14, the individual was transferred to the hospital due to tachycardia and tachypnea. A post hospital note was documented on 6/12/14 by the on-call	

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		PCP. On 6/13/14, the PCP noted that the individual was discharged the previous day. A follow-up CXR, on 6/13/14, was documented as normal. There were no additional PCP entries related to the hospitalization for sepsis. • The last quarterly assessment was in 2013. • The physician orders documented that extended release (non-crushable) medications were prescribed and administered through the gastric tube. Individual #450 • The AMA for this individual documented that the individual was a hepatitis B carrier. The plan was for GI follow-up. The active records reviewed included no further discussion of the individual's status for hepatitis B. Specifically, there was no surveillance monitoring for the adverse sequelae of chronic hepatitis B infection, such as hepatocellular carcinoma. • This individual had a history of renal stones documented for several years. The individual remained on Topamax. CT scans also showed a renal mass most likely consistent with renal cell carcinoma. This finding dated back to 2012. The most recent CT showed a staghorn renal calculus. The individual had only one functioning kidney. • A neurology consult, dated 5/22/14, noted that the individual was taken off Topamax following a recent hospitalization. Keppra was started. The neurologist documented "It is unclear to me as to why this was done." In April 2014, following discontinuation of the Topamax, the individual experienced a seizure. This was the first seizure documented in several years. • A DNR was implemented on this individual on 2/10/14. The documentation reviewed did not provide adequate detail for the decision to implement a DNR. Documentation did not explain the rationale for electing to not provide any further treatment for the renal cell carcinoma. There was an unsigned note in the records stating that a consultant wanted to discuss treatment with the facility staff. A copy of recent literature on nephron sparing surgery was apparently provided to the facility for review and was placed in the record. However, there was no documentation that a discussion occurred with the consultant regarding surgical options. The diagnosis of possible renal cell carcinoma was suggested for nearly two years. There was no indication of why a definitive treatment decision did not occur sooner. During a previous compliance review, the monitoring team noted that failure to conduct appropriate surveillance for chronic hepatitis was associated with a poor outcome for one individual. It has been recommended in previous reviews that guidelines for management of chronic hepatitis be developed.	

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		Individual #337 • This individual was admitted in June of 2013 and had multiple medical problems. Medications included Topamax and Seroquel. • The individual was seen on 5/15/14 for an initial eye evaluation. This was nearly one year after admission. The recommendation was to have follow-up in two years. Both Seroquel and Topamax have the potential to have adverse effects on vision and, therefore, require periodic eye examinations. Topamax is associated with a sudden increase in intra-ocular pressure. Seroquel is associated with the development of cataracts and the manufacturer recommends bi-annual examination • The individual was seen in neurology clinic on 12/6/13 for an initial evaluation. This occurred six months following admission. The neurologist noted that the individual was on Seroquel "I assume for behavioral issues." The last seizure was in 2012. Individual #517 • This individual had refractory seizure disorder and had a VNS implanted. During the week of the compliance review, it was reported that the individual had a 14-minute seizure. The monitoring team reviewed the active record the day following the event. There were discrepancies in the documentation with regards to the length of the seizure. It was later reported that the seizure occurred lasted 8 minutes. The IPN entry documented that the PCP was called after the event was over and an order was given for Diastat. There was no documentation of a medical assessment until 7/21/14. That assessment occurred after the individual retuned from the emergency department for evaluation of a prolonged seizure (time unknown). • The facility's neurology policy defined status epilepticus as the occurrence of a single unremitting seizure for a duration longer than 5 to 10 minutes or frequent clinical seizures with an interictal return to baseline clinical state. Per policy, 911 was to be activated for all episodes of status epilepticus. • This individual also had a history of chronic constipation. Nursing IPN entries on 12/13/13 documented that the QIDP was concerned about the individual having loose stools. However, the nursing IPN note explained that this information was not provided to the direct care nurses. The individual continued to have multiple lose stools per IPN documentation of 12/17/13, 10:30 am. The record included multiple IPN entries, but none documented physician notification. On 12/17/13 at 12:35 pm, nursing documented that the individual was seen on sick call for diarrhea and an order was given to hold the lactulose. The record lacked physician documentation of this evaluation. On 12/18/13 at 6:35 pm, nursing documented that the individual had tachycardia	

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		with a pulse of 126, vomiting and abdominal distention. The physician gave an order to transport by van. The individual was transferred at 8:05 pm. The individual was diagnosed with severe constipation, bowel obstruction, and volvulus. Endoscopy was required to decompress the bowel. • The individual was discharged from the hospital on 12/26/13. The first physician assessment was documented on 12/29/13 and no follow-up to this evaluation was found in the active record. The next medical entry was dated 2/1/14. That note was documentation of the individual's DEXA results. Individual #160 • This individual experienced coughing which produced thick sputum during medication administration. Nursing documented on 3/2/14 at 7:00 pm that the individual would be placed on sick call the next day. There was no documentation that the individual was assessed. On 3/4/14 at 8:55 am, nursing documented that the individual was very sleepy and difficult to arouse and would be placed on sick call. The physician evaluated the individual around 12 noon and documented lethargy and weakness. The individual was transferred to the local hospital and was admitted to the intensive care unit with acute renal failure. The individual subsequently expired. There was a delay in obtaining physician evaluation for this individual. It was not clear if the individual was actually referred for sick call on 3/3/14. The records did not document any physician entry until 3/4/14. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 158 individuals. A separate document pertaining to AED polypharmacy was also submitted indicating that a total of 159 individuals received AEDs for seizure disorder. Those data are summarized below: • 53 of 159 (33%) individuals received 1 AED • 39 of 159 (25%) individuals received 2 AEDs • 28 of 159 (18%) individuals received 3 AEDs • 23 of 159 (14) individuals received 4 AEDs • 12 of 159 (8%) individuals received 5 AEDs • 3 of 159 (2%) individuals received 6 AEDs • 1 of 159 (1%) individuals received 7 AEDS The facility continued to conduct an onsite neurology clinic. A few individuals had off-campus neurology appointments. The number of clinic visits is summarized in the table below.	

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Neurology Clinics 2014		
	Campus	Community
Dec	--	--
Jan	11	2
Feb	10	1
Mar	12	1
Apr	11	2
May	5	2
Total	49	8

Forty-nine on campus appointments were completed over five months. The average number of individuals seen each month was 9.8. This was a significant decrease from the average number of 21 documented for the last compliance review. Two clinics occurred most months with no data reported for the month of December 2014. A neurologist with certification in clinical neurophysiology was conducting clinic once a month. The other clinic was held with a general neurologist.

The facility reported that 29 of 158 (18%) of individuals had refractory seizure disorder Ten individuals had undergone VNS implantation, the most recent in March 2014. None of the individuals with intractable epilepsy was being considered for treatment options, such as epilepsy surgery or VNS implantation. One individual was reported to 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. Two of the individuals were seen for general neurologic issues and not seizure management. The following is a summary of the review of the records:

- 8 of 8 (100%) individuals were seen at least twice over the past 12 months
- 8 of 8 (80%) individuals had documentation of the seizure description
- 8 of 8 (80%) individuals had documentation of current medications for seizures and dosages
- 6 of 8 (75%) 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
- 8 of 8 (100%) individuals had documentation of recommendations for medications
- 0 of 10 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc.

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		The consults reviewed indicated continued problems with seizure management: • Drug levels were not completed or were not available for clinic. • New medications were started without providing a timeframe for clinic follow-up. • Recommendations to discontinue meds, such as Keppra, were not always implemented. • Observations, such as excessive sleepiness, did not appear to always be addressed. • The information in the MOSES and DISCUS evaluations was not reviewed. • The management plan for some individuals with refractory seizure disorder was not always clear. The monitoring team met with the neurologist, clinical services director, and members of the medical staff to discuss seizure management. Some members of the medical staff had inquired during other meetings about the process for evaluation for VNS. The neurologist indicated that his opinion was that VNSs were of little use and epilepsy surgery was a better option. However, he discussed the workup required for epilepsy surgery and commented that individuals living at the facility were more than likely not candidates for epilepsy surgery due to the inability to complete the extensive evaluation that was required. No individuals with refractory seizure disorder were being assessed for non-medical interventions even though such management may be entirely appropriate. Nonetheless, the IDTs of individuals with refractory seizure disorder who are not in agreement with the decision to not consider alternative treatment may consider pursuing consultation with a different epileptologist. The clinical services director reported that the neurologists met with the facility management to discuss issues related to the facility's seizure management program. The monitoring team has emphasized the importance of providing the MOSES and DISCUS evaluations to the neurology consultants. The neurology consultant reported during the interviews that he was not familiar with the side effect rating tools and had never been informed that they should be reviewed. In order to improve documentation and provide adequate information for the IDT, the facility should consider the development of a clinic template that includes the following: • Current diagnosis and accuracy of any prior diagnosis • Seizure type, frequency, and pattern • Pro-convulsant factors, (e.g., sleep deprivation, illness, menses, photostimulation) • Prior medication use and resulting effects • Current medications: rationale for use and current effectiveness	

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		• Identification of potential drug to drug and drug to food interactions of current medications • Consideration of untoward side effects/adverse effects of drugs with a description of actions taken to monitor/address potential side effects • Polypharmacy reduction: consideration of AED taper with expected timeframes. • Discussion of consideration of alternate treatments (other than AED therapy) • Potential seizure management issues that impact cognitive, behavioral, or emotional functioning • Plan of care with short and long-term goals for seizure management. This plan is to include preventive care information (bone health, need for folic acid, etc.) and instructions for seizure management Facility staff received seizure training in orientation. Annual refresher training was not required, but is likely needed. Staff did not appear to understand the proper course of action for individuals with status epilepticus. Facility policy required that 911 be activated. The policy defined status as an event lasting five to 10 minutes. The monitoring team learned of one individual (Individual #517) who had a prolonged seizure, possibly 8 minutes. The physician was notified after the event was over. **Access To Specialists** 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. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included 14 individuals. Eight DNRs were implemented since the January 2014 compliance review. The average age of the individuals was 50 years with a range from 23 to 82 years. The qualifying conditions were listed as anencephaly, respiratory failure, cardiomegaly, CHF, cirrhosis, and seizures. According to the facility's DNR policy, a DNR could be implemented when the individual had a terminal condition, a medically contraindicated condition, or the individual's PCP and LAR or qualified relative were in agreement to initiate an out of hospital DNR. The ability to implement a DNR at the request of the family did not clearly appear to require that a terminal or irreversible condition exist. Per Chapter 166 of the Texas Health and Safety Code, "Irreversible condition" means a	

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		condition, injury, or illness: • that may be treated, but is never cured or eliminated; • That leaves a person unable to care for or make decisions for the person's own self; and • that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal. Terminal condition was defined as an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. Several individuals with DNRs did not have a qualifying diagnosis listed and the comments noted that the DNR was done at the request of the family. The facility submitted IPNs and orders for the individuals with DNRs. Even so, the documentation of the rationale was inadequate as many cited terminal irreversible condition without documenting the nature of the condition. Given the recent implementation of a new state policy for out of hospital DNRs, the monitoring team recommends that the facility review the current list to ensure that all DNRs have been implemented in accordance with state policy. <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 clinical issues highlighted above should be addressed. 2. The facility should revise the seizure management policy and provide more detailed guidelines to staff for the management of status epilepticus.	
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 9 of the medical audits 2/11/14 – 2/12/14. 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 which are summarized in the	Noncompliance

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		table below: Round 9 - General Medical Audits Compliance (%) | | Essential | Non-essential | | Feb 2014 | 90 | 92.5 | Compliance scores were less than 80% for the following questions: • Q2 – Is there evidence the Active Problem List was updated with each new problem? • Q14 Has the Varicella (titer or vaccine) been given? • Q15 – Has the Zostavax (if >60yrs) been given? • Q26 - Was the PCFS updated at the time of the last annual assessment? • Q33 –Are responses to significant lab values documented in the IPN? • Q37 - Is the provider's documentation legible? • Q39 - Do notes regarding acute medical problems contain pertinent positive and negatives? In addition to the general medical audits, medical management audits were also completed. Nine charts, three for each selected condition, were reviewed. The results are presented in the table below. Round 9 Medical Management Audits | | Diabetes | Osteoporosis | Asp | | Feb 2014 | 86 | 67 | 68 | Corrective action plans were developed by the QA department. A total of 54 action plans were developed and completed for the general external audit. Round 9 - Corrective Action Plans | | Total Action Plans | Reviewed By QA | Remaining to Review by QA | Completed | Remaining to Complete | | General Medical | 54 | 54 | 0 | 54 | 0 | | Medical Management | -- | -- | -- | -- | -- | 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. Data were not submitted for the status of the medical management corrective action plans. The exit comments of the reviewer noted strengths and weaknesses of the medical care provided at the facility. Many of those findings were similar to that of the monitoring team. The following summarizes some of the comments	

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		of the reviewer: • There was improvement in the APL documentation. • The content of the QMS was good, when completed. • Improvement was noted in documenting family history in the AMA. • The medical staff demonstrated perseverance in completing diagnostics, such as biopsies and colonoscopies. • Documentation related to refusal of testing was inadequate. • The IPN SOAP notes needed improvement in documenting positive and negative findings. • Documentation of Varicella and Zostavax status was frequently missing. • Physician IPN notes following hospital/ER visits are encouraged. • Treatment plans in the AMA varied widely by provider. • Records audited for aspiration pneumonia did not include many factors. • There was prompt acknowledgment and implementation of consultant recommendations. The sample size for the general medical audits will need to be increased in order to achieve a sample size of 20% annually. <u>Mortality Management at LSSLC</u> There were two deaths since the last compliance review. The mortality documents for the two deaths were reviewed. Information for those deaths is summarized below: • The average age of death was 58 years with an age range of 54 to 63 years. • The causes of death were: o Respiratory failure, fluid overload, metabolic acidosis and acute tubular necrosis o Cardiac arrest, severe metabolic acidosis, multi-system failure, and septic shock • No autopsies were performed. • Both individuals died during hospitalization. The monitoring team met with the facility director, medical director, clinical services director, CNE, and QA nurse, to discuss mortality management at the facility. There was a continued need to have an objective review of medical care by a physician other than the primary care provider. It would be logical that this would be done by a primary care provider, such as an internal medicine or family medicine trained physician for adult deaths. Facility staff reported that a mortality review was done by state office. However, the findings were not provided to the monitoring team. It was reported that recommendations were produced for one of the two deaths. A review of the active records indicated that there were several issues related to the provision of health care	

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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>that should be addressed, including problems related to bowel management, physician notification, and physician response to issues. Additionally, the concern related to Topamax use and the risk of kidney stones was a significant problem for one individual who appeared to become septic after having a procedure for an obstructing renal stone. These issues did not appear to be captured in the reviews that were completed.

The monitoring team is concerned that significant medical issues were not surfaced through the mortality review process indicating the continued need for a comprehensive and objective review of the medical care to be completed with each death. This review 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 sample size of the external reviews should be increased.
2. Address the recommendations related to mortality reviews.</td><td></td></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 9 of the internal medical audits was completed in February 2014. The results are presented in the table below.

<table><tr><th colspan="3">Round 9 - General Medical Audits
Compliance (%)</th></tr><tr><td></td><td>Essential</td><td>Non-essential</td></tr><tr><td>Feb 2014</td><td>91</td><td>96</td></tr></table>
The external and internal audits for Round 9 were completed at the same time to allow for assessment of inter-rater reliability.

Medical management audits were also completed in February 2014. The findings for the charts reviewed are listed below.

<table><tr><th colspan="4">Round 9 - Medical Management Audits
Compliance (%)</th></tr><tr><td></td><td>Diabetes Mellitus</td><td>Osteoporosis</td><td>Asp Pneumonia</td></tr><tr><td>Feb 2014</td><td>93</td><td>80</td><td>93</td></tr></table>
The audits indicated significant differences in the scores between the external and</td><td>Noncompliance</td></tr>
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		internal scores. The facility will need to address inter-rater reliability. In May 2014, 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.	

Round 9 - General Medical Audits Compliance (%)		
	Essential	Non-essential
May 2014	89.9	93

Medical Management Audits Compliance (%)			
	Diabetes mellitus	Osteoporosis	Aspiration
May 2014	88	78	93

Corrective action plans were developed and implemented. The status of the corrective actions is summarized in the chart below.

Round 9 - Corrective Action Plans					
	Total Action Plans	Reviewed By QA	Remaining to Review by QA	Completed	Remaining to Complete
February 2014					
General Medical	52	0	52	0	52
Medical Management	--	--	--	--	--
May 2014					
General Medical	52	14	38	14	38
Medical Management	8	0	8	0	8

<u>Medical Quality Program</u>
The medical and clinical services directors reported that the facility had developed a medical quality program, which was comprised of three elements: (1) peer audits, (2) Quality Service Reviews, and (3) Internal/External Medical Audits.

The peer audits were completed using audit tools that were developed by the primary care providers, medical compliance monitor, and clinical services director. The tools covered several areas:

- AMAs
- Aspiration Pneumonia
- Constipation
- Diabetes Mellitus
- ER Hospital

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		• GERD • Metabolic Syndrome • Osteoporosis • Seizures • Tuberous Sclerosis The audits were implemented in April 2014. Each month, the physicians completed record audits based on the clinical indicators. Each record could potentially be audited for a number of conditions. Thus, a total of 100 audits were completed from April 2014 to June 2014. The facility calculated overall compliance data and compliance for each of the conditions audited. It was reported that corrective actions were implemented. Quality programs require a number of structures, including a QI Committee, calendar, clinical practice guidelines, policies and procedures, peer review process, chart audits, tracking systems, and data sources. As discussed above, LSSLC had a number of these processes in place and this was a good start for development of a comprehensive medical quality program. Even so, it appeared that a number of serious issues were not being detected with these systems. This may be a function of the reviewers or the tools that are being utilized. It would be beneficial for the facility to review all of the audit tools to ensure that the most relevant metrics are being assessed. The monitoring team has already discussed some of the discrepancies relative to clinical care standards. Those discrepancies must be addressed so that valid and reliable audit tools can be developed. The tools need to measure the specific concept that is intended to be measured. For example, if the intent of the audit was to measure the quality of the AMA, the inclusion of a metric on the presence of the physical exam would provide little information related to quality. By definition, the AMA is a medical assessment, which includes a physical exam. It would be unlikely to find one that excluded the exam. Thus, stating that 100% of AMAs included a physical provides little information about the quality of the assessment. Determining the inclusion of a detailed plan of care for each active problem would be reflective of the quality of the assessment. The medical director will need to develop additional clinical indicators and utilize current information, as was already being done with preventive care data. The metrics for hospital data should be reviewed as those presented in the self-assessment did not reflect key elements, such as the number of individuals who are admitted directly to ICU, length of hospital stay, and the number of individuals who are readmitted to the hospital shortly after discharge.	

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		Thresholds for case analysis should also be developed. Consideration should be given to conducting a case review for any individual transferred from the facility who requires admission directly into the Intensive Care Unit or those individuals who are re-admitted to the hospital within a week of discharge. Overall, significant progress was seen in this area. LSSLC should continue to identify metrics (process, outcome, and structural) to be measured. A specific medical quality committee is needed. As a formal committee, the medical director should serve as the chairperson and minutes should be taken and forwarded to the facility director and QA department. 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 recommendations in the body of the text should be addressed.	
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, 4/18/14 • LSSLC Policy, Preventive Health care guidelines, 11/5/13, 5/1/14 • LSSLC Policy, Medical Care Quality Management Procedures and Guidelines, 4/21/14 • LSSLC Policy, Pneumonia Committee, 3/4/14, 5/2/14 • LSSLC Policy, Aspiration Pneumonia Guidelines, 5/2/14 • LSSLC Policy, Evaluation Process for Enteral Feeding, 3/1/14 • LSSLC Policy, Medical Emergency Response Drills, 1/16/14 • LSSLC Policy, Skin Integrity Committee, 3/7/14 • LSSLC Policy, Guidelines for Admission to Acute Care Facility Off Campus Medical Appointment and on Campus Clinics • LSSLC Policy, Planning End of Life Care, 5/22/13 • 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, 3/17/14 • 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	Noncompliance

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		• Dental Procedures Manual
		• Psychiatry Policy and Procedure Manual
		• Clinical Protocols
		  ○ Aspiration Risk Reduction
		  ○ Constipation
		  ○ Diabetes Mellitus
		  ○ Enteral Feeding
		  ○ Metabolic Syndrome
		  ○ Osteoporosis
		  ○ Seizure Disorder
		
		The facility submitted a number of policies, procedures, and guidelines that were not signed and did not include any dates of implementation. Topics included non-emergency medical services, use of AEDs, and tuberculosis screening. Several of these policies were listed in the facility's document submission for policies and procedures. Important policies, such as tuberculosis screening, AED use, and non-emergency medical care had not been reviewed or updated in more than 10 years. Additionally, the tuberculosis screening policy did not utilize the CDCs guidelines for interpretation, which required knowledge of the individual's "risk of being infected with TB and progression to disease if infected." The monitoring team noted that there were several inconsistencies in the dates on policies and the dates listed in the facility's policy and procedure listing.
		
		Several of the medical department's fundamental policies and guidelines included the incorrect standard. Inconsistencies were noted in several guidelines including those for breast cancer, metabolic syndrome, and osteoporosis. The standards for osteoporosis and breast cancer are discussed in section L1. Metabolic syndrome is discussed in section N3. Per the minimum common elements checklist for diabetes, eye exams were to occur every two years. The ADA recommends yearly dilated eye exams. The medical compliance nurse reported that the original version of the audit tool required annual exams, but the medical staff believed every two years was appropriate. Physicians have the option of deviating from clinical guidelines based on the use of appropriate and sound clinical judgment. However, allowing the medical staff to revise facility guidelines in a manner that is not consistent with state guidelines and generally acceptable standards of care is not appropriate.
		
		The medical department will need to review policies related to disease management and ensure that the policies, procedures, and guidelines are in accordance with state policy, are current, and reflect the appropriate standards. Moreover, there should be consistency across all policies and procedures with regards to the standards that are cited.	

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		The medical director will need to ensure that policies and procedures are updated. The medical care policy needs more detailed explanations related to the duties and responsibilities of the medical staff, particularly the requirements for post-hospital follow-up on weekends and holidays. It is standard practice for policies, procedures, and guidelines to reflect the implementation and revision dates. Policies and procedures must be signed and dated by the appointing authority. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees 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. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions, such as hypertension, hyperlipidemia, hepatitis, and other identified conditions. 2. Local policies should be developed based on state issued guidelines 3. The medical department should maintain written documentation of all training and inservices that are provided 4. The department should establish a system for annual review of <u>all medical</u> policies and procedures. 5. The recommendations above should be addressed.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o LSSLC Section M Self-Assessment, Updated: 6/24/14 o LSSLC Section M Action Plan, Updated: 6/12/14 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 LSSLC Last six months of Nursing Staffing Reports/Analysis o LSSLC Last 12 months of Infirmary Admissions o SSLC Pneumonia Event Root Cause Analysis blank form (PERCA) o LSSLC Care Plan Roundtable Recommendation, and associated ACP/AR Audit blank tool o LSSLC Physical Nutritional Management Policy, Revised: 5/6/14 o LSSLC Medication Administration Procedure, Revised: 1/14 o SSLC Medication Administration Observation Form, revised 11/12/13 o SSLC Enteral Medication Administration, Revised: 12/13 o LSSLC Nursing Storage Temperature Log and associated instructions, o LSSLC Nursing Protocol: Enteral Feeding Record Instructions #014, Effective date: 4/1/14 o LSSLC Glucometer Quality Check Sheets o LSSLC Refrigerator/Room Temperature Logs for Medication Rooms, dated: June 2014 o LSSLC Nursing Policy and Procedure, #0314 Provider Orders and Transcription, Revised: 3/24/14 o LSSLC Listing of Unit Medication Administration Times o LSSLC Medication Administration Record Master Signature Sheet, Updated: 2014 o LSSLC Last six months of Medication Variance Committee Meeting Notes o LSSLC Number of medication variances by error type, discipline, home, unit individual, category of severity, and error mode for the last six months 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, dated: 1/15/14 o LSSLC Last 10 Medication Variances and Plan of Correction o LSSLC List of all individuals admitted to the facility, 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 of Nurse Administrative Team Meetings o LSSLC New Nursing Staff Orientation, Dated 1/1/14

	○ LSSLC Nurse Competency Based Training Curriculum, Revised 3/14 ○ SSLC Nursing Procedures: Tracheostomy Care: General, Suctioning, Cleansing Techniques, Dislodgement, Dated 5/11 ○ LSSLC Medical Care Policy, Revised 4/22/14 ○ LSSLC Clinical Services Morning Meeting Minutes and associated documents 7/14/14 - 7/18/14 ○ LSSLC Training Curriculum for Emergency Procedures ○ LSSLC List of Locations of Emergency Equipment ○ LSSLC Medical Response and Drills, Revised: 1/16/14 ○ LSSLC Last six months of Code Blue or medical emergency reports, code blue drill reports and analysis, logs, and corrective action plans ○ LSSLC Last six months Executive Safety Committee Minutes ○ LSSLC Emergency Checklist for AED, Emergency Equipment for each home, June 2014 ○ LSSLC Last six months of Nurse Manager's Summary/Analysis of Emergency Checklists ○ LSSLC Skin Integrity Clinic Report, 7/15/14 ○ LSSLC Wound and Skin Integrity Meeting, Dated: 6/17/14 and 7/15/14 ○ LSSLC Skin Integrity Policy, Dated 3/7/14 ○ LSSLC Pneumonia Care Policy, Revised: 5/2/14 ○ LSSLC Aspiration Pneumonia Guidelines, Revised 5/2/14 ○ LSSLC Process for Confirming Pneumonia Diagnosis and associated Tool, dated November 2013 ○ LSSLC Last six months of Antibiograms ○ LSSLC Infection Control Meeting Minutes and associated documents for last six months ○ LSSLC AVATAR Immunization Tracking Report by Individual ○ LSSLC Mortality Recommendations last six months ○ LSSLC Mortality Summaries ○ A list of individuals ever diagnosed with human immunodeficiency virus (HIV) ○ 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) ○ Last six months of QA/QI Meeting Minutes pertaining to Section M ○ LSSLC Nursing CAPS and Corrective Action Plans 2014 Section M ○ A list of Individuals at Risks of aspiration choking, aspiration respiratory compromise, diabetes, weight, gastrointestinal problems, constipation/bowel obstruction, fluid imbalance, circulatory, cardiac disease, infections, osteoporosis, falls, fractures, skin integrity, infections, urinary tract infections, seizures, hypothermia, dental challenging behavior, and Polypharmacy side effects ○ Last six months of medication administration observation audits, analysis reports, and associated plans of correction ○ Last six months number of the medication variances error type, discipline, home, shift, unit individual, category of severity, and error mode ○ Last five individuals transitioned to the community completed nursing discharge summary ○ 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 of: Individual #235, Individual #43, Individual #484, Individual #363, Individual #417, Individual #357, Individual #316, Individual #252, Individual #12, Individual #134, Individual #116, Individual #539, Individual #526, Individual #365, Individual #218, Individual #296, Individual #332, Individual #46, Individual #586, Individual #213, Individual #450, Individual #109, Individual #225, Individual #551, Individual #430, Individual #126, Individual #114, Individual #413, Individual #368, Individual #367, Individual #108, Individual #311, Individual #361, Individual #300, Individual #571, Individual #129, Individual #592, Individual #309, Individual #370, Individual #74, Individual #556, Individual #110, Individual #428, Individual #59, Individual #588, Individual #181, Individual #287, Individual #228, Individual #204, Individual #313, Individual #449 Individual #500 <u>Interviews and Meetings Held</u>: o Mary Bowers RN, BSN, Chief Executive Nurse (CNE) o Laura Flowers RN, BSN, Nursing Operations Officer (NOO) o Sarah Hensarling, RN Infection Preventionist (IP) o Sarah Heckendorn, RN, BSN, Hospital Liaison Nurse o Elizabeth Moody, RN, BSN, Immunization Nurse o Nurse Compliance Officer, Stephanie Steel, RN (NCO) o Nurse Educator, Joyce Adams RN, BSN o Tanesha Wilson RN, BSN, RN Case Manager Supervisor o Carmen Sanders, RN, Infirmary Nurse Manager o Quality Assurance Nurses, Paul Vann RN, and La Donna Erwin-Brooks RN, BSN o Nurse Managers, Campus RN Supervisors, Staff RNs, LVNs and DSPs o Immunization Meeting,-7/17/14 <u>Observations Conducted</u>: o Residential areas and Infirmary, various time of the day and evening o Medication Room Inspections various time of the day and evening o Medication Administration Observations o LSSLC Skin Integrity Committee Meeting, 7/14/14 o LSSLC Nursing Monthly Management Meeting, 7/14/14 o LSSLC Infection Control Committee Meeting, 7/15/14 o LSSLC Skin Integrity Clinic, 7/15/14 o LSSLC Pneumonia Committee Meeting-7/16/14 o LSSLC Home Team Meeting, 7/16/14 o LSSLC Medication Variance Committee Meeting, 7/16/14 o Mortality Meeting, 7/17/14 o Section I Meeting, 7/17/14 o ISPA, 7/17/14

	○ Individual Support Plan Meeting, 7/17/14 ○ LSSLC Clinical Services Meeting, 7/15/14, 7/16/14, and 7/17/14
	Facility Self-Assessment: The facility submitted its self-assessment and action plans for section M. For each of the sections, the facility described the activities, action steps, and results. In addition, there were graphs, and there were plausible explanations for changes that affected progress toward areas deemed by the facility that were not found in substantial compliance. The Nursing Department implemented 63 action steps since the last report for making improvements (e.g., infection control, skin integrity) for which 44 were accomplished. The remainder were aligned with timelines for completing the action step process. The facility stated they were in substantial compliance for M4 and M6. The monitoring team was not in agreement.
	Summary of Monitor's Assessment Changes in nursing leadership since the last visit included the following positions: • Nurse Educator, • Program Compliance Nurse • Infirmary Nurse Manager • Infection Preventionist/Skin Integrity Nurse The CNE, during the recruitment phase for these positions, assumed responsibility as the chair for Infection Control, Skin Integrity Committees, and the newly established Pneumonia Committee. The Immunization Nurse managed the oversight of the Wound Clinic. The nursing department did not experience any occurrences of not meeting their set minimum staffing ratios during this reporting period. The nursing department had in place a robust database for capturing the number of audits conducted and findings from the audits. These were presented at the monthly Nurse Managers meeting to discuss underlying reasons for any trends associated with the audits. The facility implemented guidelines for Infirmary Nursing Admission/Assessment processes that included timelines for completing the assessments. Improvements made to Infection Control and Skin Integrity Practices included: • Development and implementation of Hand Hygiene education, audits, and posting of hand hygiene

	reminders • Development and Implementation of education in Skin Care and Wound Prevention for nurses • Contracting a certified wound specialist • Establishing a designated area for conducting wound clinic Based on observations and record reviews, however, issues associated with skin integrity continued to be very problematic. The Hospital Liaison had obtained remote access to "real time" hospital records for the facility. The RN Case Manager Supervisor had a designated RN Case Manager mentor to assist RN Case Managers with RN Case Management activities, such as completing Comprehensive Nursing Assessments and developing IHCPs. Aspects of Medication Administration were not found to be consistent with the facility's own audits, such as related to general accepted standards for administration/storage/security of medication, and following established standard of infection control practices associated with administering 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 monitoring team, accompanied by the RN Program Compliance Nurse, conducted an independent review through observation rounds on each of the units/homes. The monitoring team reviewed records onsite, interviewed nursing staff and DSPs, and observed nurses performing assessments, application of dressing, providing enteral nutrition, and administering medications through various routes. The monitoring team also attended a variety of meetings and a Skin Integrity Clinic. In addition, the monitoring team reviewed the facility's submission of requested documents, self-assessments, actions plans, raw and analyzed data/audits, and information provided in section M. More specific information regarding findings from the independent observations, interviews, and record reviews are found throughout this report. <u>Staffing, Structure, and Supervision</u> The CNE held monthly Nursing Administrative meetings that showed continued efforts toward recruitment and retention of nursing staff. The CNE met with the LVN staff to make a schedule change in response to their request for every other weekend rotation. The CNE implemented the weekend rotation on 4/1/14. The Nursing Department had four leadership positions that became vacant since the last monitoring team visit. In addition to the leadership positions, the Nursing department had filled six other vacancies. The vacancies included four RNs and two LVNs. The CNE reported the reasons for the vacancies were related to salary, a nurse completing a practitioner program, and retirement. All of the nursing positions, Nurse Educator, Infection	Noncompliance

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		Preventionist, Program Compliance Nurse, RN Infirmary Nurse Manager, were nurses who were employed at LSSLC and received promotions (with the exception of the Infirmary Nurse Manager). All of the nurses had been in their new positions for one to two weeks. The CNE and NOO were observed by the monitoring team providing daily instructions/orientation when supporting the nurses in their new roles. For each position, there was a description of their roles, functions, and expectations of their workload. All of these positions have major roles and functions that impact upon continued progress toward meeting substantial compliance with section M. The monitoring team interviewed each of the new hires and found each to be committed to their new roles, but will need substantial guidance. For example, the IP was not certified, and did not have experience in the specialty field of infection control. The CNE orientation plan for the IP ensured that she received training from other facilities and experts. The CNE should assure, for each of the specialty area positions, that there is a written orientation plan that is specific to the specialty area. The Nursing Department had 149 budgeted positions, of which 78 were RNs and 71 were LVNs. Three of the RN positions were assigned to other departments (e.g., QA, psychiatry). Five LVNs were assigned to medical. The current census for LSSLC, at the time of the review, was 328. The CNE had established minimum ratios. The facility had not incurred any instances of falling below the established ratios for the past six months. The facility continued to require the use of Agency Nurses. The facility reported most of the agency nurses had been with the facility for two years or more. The Nursing Department maintained staffing data that included hiring, terminations, absences, call-ins, and overtime. The facility reviewed their own trends to make schedule changes. The CNE continued to act as the Chair for the Infection Control, Skin Integrity, and Pneumonia Committees in the absence of an Infection Preventionist. The Immunization Nurse managed the oversight of the Skin Integrity Clinic, for which the facility had contracted with a certified wound specialist. <u>Availability of Pertinent Medical Records</u> The monitoring team randomly selected five individual's individual notebooks from different home/units to review: Individual #235, Individual #417, Individual #367, Individual #296, and Individual #110. The monitoring team found: • Five of five (100%) of the individual notebooks were located on the home/unit. Individual #235's book did not contain her ISP. • Four of five (80%) of the individual notebooks contained the individual's current ISP.	

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		The individual notebooks were problematic, as below: • Individual #367: ISP was found to have crumpled, folded over sheets of paper, loose paper, and generally appeared in disarray. • Individual #417: contained health care plans/staff instructions for problems that were inactive. Staff instructions were not written in easy understandable terms. • Individual #417: contained a Menstrual Record for documenting menses. The record also documented a hysterectomy in 1993. • Individual #296: Aspiration Trigger Sheets were blank for a reviewing by the shift nurse. If the individual notebooks are to be a guiding source for staff, it is important to that attention should be given to ensure they have the most up to date information, and that the information is written in understandable terms (e.g., nursing staff instructions). A review of active records found: • The majority of the Nursing IPNs were written in the SOAP format. • Late entries, when noted, were appropriately documented. • Most nursing entries were legible, although signatures and titles were not. • No nursing entries were found written outside the margins. • Almost all nursing entries were timed. • There were missing documents per the document request, such as the Infirmary Nursing Assessment for Individual #46 and Individual #450. • More often, verbal/telephone physician orders taken by nurses were not documented in accordance with facility policy (e.g., Individual #450). <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The monitoring team attended three of the daily Clinical Morning Meetings. The meetings included a review of the status of individuals with acute changes in status, consultations, hospital reports, restraints, and 24 hour nursing reports. These included individuals that were hospitalized and/or admitted to the Infirmary or were evaluated in the Skin Integrity Clinic. During these meetings, there were discussions among the team members regarding actions taken, such as consultation or actions needed related to the individual's presenting or ongoing health problems. The monitoring team reviewed a sample of individuals with Acute Change in Status. Findings from these reviews are found in the subsections of this report. <u>Hospital Liaison Activities</u> The Hospital Liaison reported that visits/contacts were made to the hospital daily. The	

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		Nursing Department had an assigned back up nurse for visits/contacts on the weekends and holidays. The Hospital Liaison nurse reported that she highlighted the reports daily for items deemed requiring follow-up or addressing by the team, such as input from the morning clinical meeting. In addition, while at the hospital, she often sent updated information via phone messages. The Hospital Liaison nurse had been instrumental in obtaining remote access for viewing "live records" for the two tertiary care hospitals used by the facility. As the process for ascertaining the records was new, there was ongoing training for others who have been granted access (e.g., physicians to the records). The Hospital Liaison reported she conducted her own nursing assessment of the individual, reviewed the available hospital record, and interfaced with the hospital staff. In addition, she assured that the DSP was instructed on signs and symptoms for reporting to the hospital nurse. <u>Emergency Room/Hospital Liaison Reports</u> <u>Hospitalizations/ER/LTAC Nursing Assessments</u> The monitoring team's sample included individuals that were transferred to the Emergency Room and subsequently hospitalized due to their acute changes in status. For the period of 4/7/14 through 6/1/14, there were 10 hospitalizations and one emergency room visit. From the list of individuals, the monitoring team randomly selected a review of two individuals who had three hospitalizations. • Individual #109, (5/18/14 pyrexia, tachycardia, pneumonia), • Individual #46, (4/7/14 UTI, hypoxia, hypotension, 6/20/14, aspiration pneumonitis, dehydration) • Individual #357, (4/3/14 - abdominal distention, tachycardia, 4/8/14 - sepsis, tachycardia, Dilantin toxicity, left basilar pneumonia, 5/10/14 – emergency room hypoxia, 5/14/14 - fever, pneumonia, seizure, 6/6/14 - sepsis), • Individual #129, (6/1/14 - pneumonia) • Individual #556, (5/9/14 – pneumonia), • Individual #586, (3/30/14 - CHF exacerbation, acute pulmonary edema, anasarca, hypoxemia, acute dyspnea, 4/6/14 –cellulitis) • Four of 11 (36%) Hospital Transfer Forms for each of the emergency/hospitalizations contained documentation of communication between the transferring and receiving nurses. The remaining six could not be assessed for compliance due to missing documents. • Five of 10 (50%) Hospital Liaison Reports showed daily oversight by the Hospital Liaison or her designee, including weekends and holidays, either through visits to the hospital and/or contact with the hospital. The remaining four could not be assessed for compliance due to missing documents. • Four of 11 (36%) Hospitalization ER/LTAC Assessments were found in the	

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		record. Two of four (50%) were sufficiently completed. For example, Individual #556's post hospital admission for pneumonia had an omission for a complete assessment of his respiratory status. The remaining six could not be assessed for compliance due to missing documents. • One of one (100%) Post Hospitalization/ER/LTAC Nursing Assessment for Individual #235, residing at skilled facility, showed that she was visited daily, from 5/14/14 through 5/20/14, in preparation for a transfer to LSSLC. A Post Hospitalization/ER/LTAC Nursing Assessment, dated 5/20/14, was problematic for specifying information about the changes in the individual's condition or Health Care Needs that included other relevant IDT members (e.g., Infection Preventionist, emergencies associated with the tracheostomy). • Individual #109's Nursing IPN documented, on 5/15/14 at 4:45 pm, that the DSP had reported the individual was "grunting, as if in pain, and his head feels warm." The Nursing IPN documented vital signs, an oxygen saturation rate, individual pain level, and a head to toe assessment. Abnormal vital signs for temperature elevation and tachycardia heart rate were reported to the physician. The physician ordered a 911 transport to the hospital. The individual was subsequently admitted to the hospital with diagnoses of pyrexia, tachycardia, and pneumonia. The abdominal pain protocol was adequately implemented for abdominal pain and abnormal findings of the vital signs. This was a positive example of a nursing assessment using the abdominal distention/pain protocol. • Prior to the hospitalization, the Nursing IPN contained documentation that Individual #109 had not had a bowel movement (i.e., 5/2/14 (two days), 5/7/14 (three days), 5/10/14 (three days), 5/14/10 (two days)). The IPN Nursing note documented for each of these dates that a PRN enema was administered. The Nursing IPN notes did not address whether or not the individual was receiving an adequate fluid intake, or that the intake and output were sufficiently being monitored. The individual had a risk rating of medium for constipation. The individual had received 17 enemas in the previous ISP year. It did not appear that the team understood the seriousness of constipation, the problems with reliance on outside assistance (enemas) for bowel management, and being at increased risk for experiencing related medical issues. The individual should have been considered high risk for constipation. The IHCP documented to assess for abdominal distention and measure abdominal girth. None of the May 2014 nursing IPNs included the nursing interventions for measurement of the individual's girth. The constipation protocol was not sufficiently and consistently followed. • Individual #46: on 4/1/14 at 5:00 pm, DSP reported that the individual felt cold.	

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		Nursing assessment included abnormal vital signs of a pulse below 60, and a temperature of 95.2 (route not documented), thus, it was unknown if the individual's temperature was actually lower. The nursing diagnosis documented "low temp not <95%." The IHCP interventions included following the Nursing Protocol for Hypothermia. The protocol interventions were not followed for a neurological and cardiovascular assessment. The Nursing IPN did not contain the individual's normal baseline for comparing the temperature, or his baseline vital signs. The nursing plan did not include an assessment for decreased output. On 4/2/14 at 9:00 am, the record documented that the medication nurse reported that the individual looked sick. Vital signs were obtained and a head to toe assessment was performed. The nurse assessment documented "congestion" for which a prn treatment order for congestion was administered. The next available note documented, on 4/6/14 at 11:40 am, that the RN was notified by the medication nurse that the individual had congestion in his lungs. The nurse performed a nursing assessment to include vital signs. Her assessment documented increased congestion in airway/afebrile, 02 sat 98%. PRN nebulizer treatment was administered. The Nursing IPN documented the individual's response to the treatment "to have improved, but congestion remains in upper airway." The physician was contacted and gave an order that for the individual to be seen in sick call on Monday 4/7/14. On 4/6/14, the individual experienced an episodic event of hypothermia with a temperature of 93.5. The physician was notified. Physician orders included "Bair hugger" (a warming device for raising an individual's hypothermic temperature). On 4/7/14 at 8:15 am, the medication nurse reported that the "individual sounds congested and doesn't look good." The individual's vital signs (blood pressure) was 92/52, a low blood pressure. The nursing assessment included notification to the physician on 4/7/14 at 8:20 am. The individual was evaluated on 4/7/14 for dyspnea (difficulty in breathing) and sent to the emergency room. He was admitted to the hospital on 4/7/14 with hypoxia and hypotension. • On 6/17/14 nursing was notified that Individual #46 had coughed during his meal by the DSP. The nurse performed a nursing assessment to include vital signs. Staff instruction were documented to include signs and symptoms and report to the nurse. The Respiratory protocol was not followed for assessing and documented at least every shift until after 48 hours symptoms have resolved. The next nursing entry was documented on 6/20/14 at 1:30 pm, in which one the nurses found the individual in his room unresponsive. The individual's vital signs were abnormal with 61% oxygen saturation rate. The second nurse left to obtain a crash cart. The emergency response system was initiated. 911 was called and the individual was transported to the emergency room. On 6/20/14, the physician documented that he was called to see the individual related to being found choking and in respiratory distress. The	

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		individual was admitted, on 6/20/14, with aspiration pneumonitis and dehydration. • On 6/1/14 at 4:30 am, the DSP reported that Individual #129 had vomited. The nursing protocol for vomiting was not followed for including hemoccult, based on the description of the color of the emesis. On 6/1/14 at 6:30 am, a report was received from two DSPs that "for the past two days individual has been crying and saying hurt." Nursing assessment included implementing the PRN order for an enema. At 8:40 am on 6/1/14, the Nursing IPN indicated the physician was notified of the vomiting. A new order was received for administering an enema. At 5:00 pm, the Nursing IPN noted "individual is harder to get to respond." The physician was notified and the individual was transported by 911 to the hospital. She was admitted with a diagnosis of pneumonia. The record documented a nursing assessment on 6/1/14, at 11:30 am. The next assessment was performed at 4:00 pm. The monitoring team also reviewed the record for events prior to the hospitalization and found the individual had episodes of vomiting on 5/5/14. The vomiting protocol was not followed. • The Nursing IPN notes gave the appearance nurses were not always curious as to the underlying reasons for the occurrence of vomiting, and ongoing associated problems with constipation. Nursing assessments did not include historical information about previous events that led up to the acute event. More often, the reviews above did not include a plan for assessing the individual's intake and output when individual had vomiting/constipation. Nursing assessments did not evaluate the subtle changes in vital signs that led up to the acute event when vital signs were abnormal to include a plan to increase the frequency for monitoring the vital signs. <u>Infirmary Revised Policies/Forms</u> • Infirmary Nursing/Admission Guidelines #03.14., revised 3/14 • Transfer to Infirmary/Transfer to Unit/Post Sedation /Procedure Admission/Assessment, revised 3/14 • Infirmary Admission Check list, revised 3/14 The facility received individuals in the infirmary post hospitalization, and individuals who received sedation off campus. Other admissions included individuals who required more intensive nursing care and observations, in accordance with the facility policy. A listing of individuals admitted to the Infirmary from February 2014 through April 2014 showed 50 admissions. Four individuals had a length of stay between 30 and 60 days. The longest length of stay was 95 days.	

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		The monitoring team reviewed the Infirmary Nursing Assessments initial shift report for each of the individual hospitalizations for Individual #357, Individual #556, and Individual #46 and found: • Five of seven (71%) were complete for the specific systems (e.g., Neuro for Individual #357). • Six of seven (86%) contained the Infirmary Admission Date. • Seven of seven (100%) documented the individual's allergies. • Seven of seven (100%) documented the individual's weight, and identified whether or not it was an admission weight or a current weight. • Seven of seven (100%) documented the individual's vital signs to include oxygen saturation. The pulse oxygen saturation rates did not consistently identify whether or not the results were obtained on room air or oxygen. The monitoring team also reviewed Post Infirmary Nursing Assessments for individuals who were discharged from the Infirmary, for the period of 4/4/14 through 6/3/14, for eight discharges: Individual #368 (status post (s/p) cataract surgery), Individual #556 (fever, hypotension, tachycardia, pneumonia), and Individual #357 (hypoxia, s/p fecal impaction, s/p sepsis, s/p pneumonia). Individual #357 had five discharges and Individual #556 had two. • Six of eight 75% Post Infirmary Nursing Assessments documented the date, time, and nurse receiving the report from the Infirmary on the date of discharge from the infirmary. • Eight of eight (100%) follow-up assessments were conducted on the day of discharge and for three consistent days. • Seven of eight (88%) were complete for assessing vital signs and a systems assessment. Even so, oxygen saturation was not consistently documented whether it was obtained on room air or oxygen. • Individual #357's Nursing IPN, associated with the required Post Infirmary Assessment, did not consistently address whether or not the skin integrity issues were improving or regressing. • Individual #556's Post Infirmary Assessment and associated Nursing IPN did not consistently address the status of the individual's edema. The monitoring team, during rounds, observed Individual #235 in the infirmary. The individual had a tracheostomy. The observation was problematic for: • Failure to assure, in the event of tracheostomy tube dislodgement, that medically necessary items were available at the individual's bedside. The next day the monitoring team returned and found all of the medically necessary items to be present. • Failure to follow established infection control practices to prevent transmission.	

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		• Failure to protect the individual airway from containments, for which the monitoring team observed a fan, which was dirty, blowing directly on the individual's face/neck/ tracheostomy area. • On 5/20/14, Contact isolation was ordered for MRSA, the record did not contain documentation the IP was notified. When staff were ask about MRSA, staff appeared unaware. No signage was located for the institution of contact precautions. • The monitoring team was concerned regarding lack of attention to infection control practices. One of the observations of the suction catheter by the monitoring team found the facility not following infection control standards of care, on two consecutive days. Even though, the monitoring team had reminded the nurses of the infection control issue. • A review of the individual's risk indicated she was high risk for choking, aspiration, and respiratory, for which the record had omission of any documents for monitoring triggers. In addition, the monitoring team reviewed the record of Individual #450 (CHF, renal failure) who had an outpatient medical procedure performed on 7/16/14. He returned to the facility and was admitted on 7/16/14 to the Infirmary. The record showed: • Post Hospital/ER/LTAC Nursing Assessment, dated 7/16/14 2:00 pm, was completed within one hour of the admission, accordance with facility policy. • The Nursing follow-up IPNs, associated with the admission, could not be evaluated for compliance because the referred to Infirmary Nurse Assessment was missing from the record. <u>Infection Preventionist</u> The monitoring team met with the Infection Preventionist (IP), recently promoted to the position 7/1/14. Prior to the promotion, she was in the position of an RN Case Manager. The monitoring team conduced a brief interview with the IP because at the time of the monitoring team visit she was in orientation/ training. The IP reported that, while she did not have experience as an IP, she was very interested in the aspects of Infection Control. The nurse reported that her orientation to date had included training in certain infections, and she was scheduled to visit another facility to work with another IP. The CNE reported that the state office had hired an Infection Control Company to visit each of the facilities to assess their IP programs. The CNE reported that Lufkin was scheduled for August 2014. The monitoring team will follow-up at the next visit as to the status of the visit and any assessments from the external infection control resource. The CNE should ensure there is a substantive orientation plan for meeting the roles and responsibilities of the IP.	

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		Infection Control The monitoring team observed Individual #361, who was isolated for C-diff, in the Infirmary and found: • The individual was located in a room set up to provide isolation. • Signage was located on the door. It stated the type of contact isolation and instructions, but were not written in language that would be easily understood by all staff. • An isolation cart was present and contained sufficient gowns, gloves, and masks. • There were adequate containers for disposing of waste and soiled linen. • The facility had a record for documenting terminal cleaning of the isolation room and area. • The monitoring team, during rounds on two consecutive days, found the isolation room exit door open. Because C-diff is a spore-forming organism and environmental contamination can occur, it is important to ensure exit doors to the room are closed. Infection Control Committee Meetings • The facility scheduled and held Infection Control meetings in accordance with their policy. • The facility through their regular Infection Control Meetings had: o Developed and Implemented Environmental Checklist, 6/14 o Provided Education on Chikungunya (new mosquito virus), and measures for prevention of mosquito bites o Initiated a Pneumonia Committee o Implemented and conducted handwashing and standard precautions observations o Held discussions to revisit how monitoring was conducted for hand hygiene and standard precautions o Implemented on 6/12/14, Corrective Action Plan to reduce reoccurring infections, with a date of review for 8/15/14 • The monitoring team attended an Infection Control Meeting where there were discussions of next steps for implementing the Environmental Checklist, and continued discussions of ways to observe the day to day practices of staff performing hand hygiene and standard precautions that were unscheduled. • In addition, the facility reviewed its own data during the meeting. o June 2014 checklist showed an overall score of 94% for the 480 items reviewed o Reported on their infections, however, the discussion did not appear to examine any increases or decreases in the number of infections, what was working, and what was not working regarding their infection	

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		control systems to effectively reduce the transmission of infections. The monitoring team reviewed the facility's data for the highest to lowest numbers of infections for the period of February 2014-June 2014 UTI 55 Pneumonia 38 Conjunctivitis 34 Wound Infection 34 Fever of Unknown Origin 34 Other 34 URI 28 Otis 20 Cellulitis 19 Totals 296 The CNE reported that the state office had contracted with an Infection Control consultant to review all facilities and LSSLC was scheduled for a visit in August 2014. The monitoring team will follow-up on the activities associated with the scheduled visit. <u>Immunizations/Employee Health</u> The monitoring team met with the Immunization Nurse and reviewed Immunization records of Individual #204, Individual #116, Individual #357, Individual #592, and Individual #584. The monitoring team requested the documents, consents, and forms as both a verbal and written request. However, for each of the records a copy of the VIS was not located. • Five of five (100%) had an immunization record • Five of five (100%) documented the applicable vaccines or proof of immunity/or titers • Five of five (100%) had documented consents The monitoring team also randomly selected six records from the sample for review: Individual #46, Individual #556, Individual #225, Individual #368, Individual #357, and Individual #109 and found: • Six of six (100%) had an immunization record • Five of six (83%) documented the applicable vaccines or proof of immunity/titers The Immunization Nurse reported that Immunization data had been entered in the AVATAR database. However, only individual reports could be produced. She had maintained an additional database that showed, as of 5/27/14, the percentages of	

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individuals with a current immunization/immunity status based on the Immunization schedule for the individual. The statuses of the vaccinations/consents reported were based on a census of 332.

Hep A	Hep B	TDAP	Varicella	MMR	Pneumococcal	Zostavax
97.77%	97.89%	93.97%	86.53%	96.98%	97.89%	52.11%
2 delinquent for second dose in series out of 87 ordered by PCP	7 of 332 not complete	20 of 332 pending	7 pending of 52 eligible	10 not completed – obtaining consent/records	7 are not complete, obtaining consents	71 are eligible- 37 given with 34 pending review by PCP and/or consent

The facility reported 97.35% were vaccinated for flu. The remaining were three declinations by the individual's guardian, five with documented allergies, and one MD declination.

Based on the census of 332, 99.40% were reported to have received their PPD. Even though the facility submitted a line listing of individuals with a positive PPD, the number of individuals who had an annual questionnaire or if anyone was currently taking an anti-tuberculosis drug, could not be discerned.

In discussions with the Immunization Nurse, the monitoring team provided technical assistance regarding the importance of the VIS, documentation of the VIS, and regulatory requirements. The Immunization Nurse was unaware of the ability to have access to the Texas ImmTrac system for vaccination history for children under 18, as one of the resources for obtaining an immunization history for new admissions. In addition, the facility immunization record format was dated as 8/94. The facility should assure the Immunization Nurse has received adequate orientation regarding maintaining an Immunization Program that meets the necessary regulatory requirements. The CNE should ensure the facility's immunization form is current with the standards documenting the VIS and Immunizations.

Skin Integrity Committee/Wound Clinic
New/Revised Policies/Procedures

- Skin Integrity Committee Policy, 3/1/4, New

Training/Inservice

- Nursing Wound Prevention Inservice

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		The monitoring team attended the Skin Integrity Clinic chaired by the CNE. The CNE reported that no data were available due to failed data systems. A synopsis for June 2014 indicated that there were 26 individuals with skin integrity issues. For May 2014, there were nine pressure wounds for six individuals. The May 2014 Pressure Wounds were facility acquired. A Case study for Individual #46 was presented, which detailed from week to week from May 2013 through May 2014, the status of his ongoing Stage II decubitus. During discussion, the team identified problem areas that impacted healing processes, and discussed solutions for remedying those ongoing problems. The facility discussed moisture sensing alarms, but the committee found that this was not available. There was no discussion of processes or systems in place to assure prevention measures were effective. The monitoring team also attended the Wound Clinic. The Immunization Nurse was currently managing the oversight of the clinic and appeared to work well with the Nurse Practitioner. Improvements to the Wound Clinic • Wound Assessments were performed by a Nurse Practitioner certified in wound care • The room was equipped with a sink, with running water, soap, and towels. • Dressings and Skin Protectants/Remedy Products were available and accessible • The room provided an exam table with adequate lighting • The room provided a level of privacy for the individual • Records were brought to the clinic Improvements needed: • Evaluate processes that can be effective time savers. For example, the Nurse Practitioner reported most of his time was spent in documenting on all the forms the facility was requiring. Consider the use of a Dictaphone for dictating the consultation. • Ensure DSPs bring necessary supports that may be needed during the visit, such as the individual's preferred briefs or wipes. • Consider a revised format that tracks each of the clinic visits by individual, and that documents the observations and treatments, in order to have at a glance the individual's history and response to treatment. • Even with the above improvements, there had been little progress in moving toward the goal standard of having zero pressure areas. The decubitus ranged from unstageable to Stage IV, all of which concerned the monitoring team. The facility should assure systems are in place to assure there are integrated systems for monitoring and assessing individual who have potential risk for skin	

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		integrity issues. The monitoring team reviewed Individual #556's record, for which there were serious concerns, due to the severity of a decubitus, diagnosed on 7/15/14 as a Stage IV. The facility should immediately review what actions or lack of actions, led to the individual acquiring a significant change of status. • On 6/24/14, the individual was released from wound clinic with instructions to prevent pressure between his toes. The individual was referred to clinic on 7/15/14 and was assessed as having new wound on his left foot heel. The wound practitioner staged the wound as a Stage IV. The individual was admitted to the Infirmary on 7/9/14. Records prior to the Infirmary admission, dated 6/25/14 through 7/8/14, were reviewed and found to contain no documentation of a skin integrity issue, or that the individual, based on his age and potential risk for skin integrity skin assessments for potential pressure areas, was being sufficiently monitored. On 7/15/14, the Infirmary Nursing Assessment documented the wound on his heel. As required by the facility's policy, there was not a corresponding Nursing IPN note regarding the finding. No order was found for referral to the wound clinic. In February 2014, the IDT during the annual ISP, had deliberated, and raised the risk for skin integrity from low to medium, based on a Braden score of 18 and individual was dependent upon staff for hygiene and personal care due to incontinence. <u>Emergency Response Activities</u> The monitoring team selected six units/homes for ascertaining the presence and functionality of the AED and emergency equipment and found: • Four of four (100%) Suction Machines were located in the dining room, and demonstrated as operational. • Six of six (100%) of the Emergency Equipment, AED, Oxygen, Suction Machine, Emergency Bag, were present. • Six of six (100%) of the AED Pads were in date. The AED was found to be charged, and ready for emergency use. • Six of six (100%) of the Emergency bags were found properly and secured with a numbered pull lock. • Six of six (100%) of the Emergency checklists, viewed onsite for the date of the review by the monitoring team, had been completed and initialed. • Six of six nurses (100%) proficiently demonstrated the use of the emergency equipment (e.g., suction machine, oxygen, AED). • Four of six nurses (67%) responded correctly when quizzed on how equipment would be operable in the event of power outage (e.g., knowledge of and location of red plugs).	

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		• 18 of 18 (100%) Emergency Oxygen Tank and Suction Machine June 2014 Checklists were completed with no blanks in accordance with facility policy for June 2014. • 17 of 17 (100%) AED and Emergency Bag June 2014 Checklists were completed with no blanks in accord with facility policy. • Six of six (100%) Walkthrough Checks for emergency equipment, submitted by the facility's Risk Management Department, revealed no missing items at any location. The monitoring team suggests including, in the emergency response training, what to do in the event of power outages. The nursing department document summary provided information that check off sheets were reviewed monthly by the Nurse Managers, and it documented corrective actions for each of the findings. The facility did maintain a formal schedule that included all shifts for conducting Mock Medical Emergency Drills in accordance with facility policy. For these drills, the facility engaged in using different types of mock emergency scenarios, such as choking. The overall average for passed drills for February 2014 through April 2014 was 88%. No data were submitted by the facility for May 2014 and June 2014. For each of the failed drills, the facility documented the reason and instructor's actions taken. 2014 | February | March | April | May | June #of Drills | 35 | 34 | 33 | No Data | No Data Passed | 30 | 30 | 30 | No Data | No Data Failed | 5 | 3 | 3 | No Data | No Data % Passed | 86% | 88% | 91% | No Data | No Data The facility document submission showed no delinquent staff regarding certifications in CPR. The facility initiated its emergency response system, on 6/20/14, for a choking and respiratory distress incident for Individual #46. The activation of the emergency response for this case was a positive example of the effectiveness of the emergency response system. However, the monitoring team was unable to discern what processes or documentation the facility had in place for reviewing this emergency and other actual emergencies.	

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		Quality Enhancement Efforts The facility had implemented a number of quality enhancement efforts associated with areas as being identified as problematic by the monitoring team. These efforts included: • Training Education/Hand hygiene Observations • Training Education/Standard Precautions • Implement Environmental/Infection Control Evaluations/Universal Precautions • Providing a Certified Wound Nurse to evaluate wound/skin issues • Develop and Implement a Skin Integrity Committee Policy • Develop and implement a training/education Acute Respiratory Distress The Nursing Department submitted a summary of Nursing corrective action plans (CAP). For each of the M-001, M-002, and M-003 plans, there were 17 action steps. The report showed 15 of 17 that were due and were fully implemented. For the remaining two action steps, the report documented "as of 4/14/14, 20 employees have failed to comply with hand washing campaign." No additional information was available as to the current status of the action step. The other action step was to evaluate the effectiveness of hand washing program using the backlight and GLO Germ powder. During rounds on the units/homes, the monitoring team asked the Nurse Managers questions regarding the use of the educational tools, such as backlight and GLO Germ (tools used to detect if hand washing techniques were effective). Unfortunately, when the monitoring team quizzed about the use of the educational/evaluation tools, one of the Nurse Managers, reported they were not aware of the training tools. The Nurse Educator also reported she was had not used the tools. The QA nurses reported an established practice of discussing and reviewing with the Nursing Department when findings from audits resulted in disagreement. The practice involved a joint review between the two raters where the specific questions were discussed. Discussion included whether or not the question was applicable. For example, a disagreement for skin resulted in a 50% score. Nursing and QA nurses planned to meet and further discuss the disagreements. The monitoring team will follow-up at the next visit for any changes made as a result of the discussions. The overall inter-rater agreements for April 2014 and May 2014 audits were 93%. The facility QA nurses also perform the following activities: • Conduct Inter-rater reliability with Nursing Audits ○ Standard Precautions, Respiratory Distress/Aspiration, Enteral Feeding Tolerance/Complications, Urgent Care/ER/Hospitalizations, Fall or Suspected Fall, Acute Illness and Injury, Skin Integrity • Complete Clinical Death Summaries	

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		• Attend mortality reviews • Attend QA/QI, Medication Variance, Infection Control, Skin Integrity Committee Meetings The QA Nurses provided a copy of the Mortality CAP tracking, February 2014 through April 2014, for which there were two deaths. There were 15 recommendations, for which six were recommendations for Nursing. All of the six nursing recommendations were documented as completed. Even so, the nursing recommendations did not include action steps for how the facility planned to evaluate the effectiveness of the implemented recommendations. For more information regarding mortality, see section L. The facility's self-assessment indicated they were not in substantial compliance, and the monitoring team was in agreement. For the next six months the facility should focus on assuring: 1. Nursing, DSP, and staff are re-educated about the signs/symptoms of constipation, the importance of being knowledgeable about the individual's bowel habits, the use of laxative, prn enemas, and health conditions that can occur when constipation is not appropriately managed. 2. Nurses are educated on the two types of hypothermia, primary and secondary, and conditions associated with the underlying reason for the hypothermia. 3. Systems are in place to assure there are integrated systems for monitoring and assessing individuals who have potential risk for skin integrity issues. 4. Staff are following acceptable standards of infection control and applicable isolation procedures. 5. IP serves as a resource to all staff and all departments relating to prevention of infections. 6. Systems are sufficiently in place for staff and individuals that focus on risk of infections and practices to decrease risk, and systems to facilitate recognition of infections increases, clusters, and outbreaks. 7. Nurses proficiently demonstrate both classroom and bedside procedures when taking care of an individual that has a tracheostomy, and are sufficiently trained to recognize potential problems that can occur with individuals who have an artificial airway (tracheostomy). 8. Review of the revised December 2013 Tracheostomy policies and references to ensure they are congruent with current standards of care, respiratory, medical policies, and infection control practices.	

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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.	Since the last review, the RN Case Manager had an RN Case Manager mentor whose roles and responsibilities were to mentor the RN Case Managers through a review of their Nursing Assessments, IHCPs, and staff instructions. The mentor also, when there was a vacancy for an RN Case Manager, assumed the caseload until the vacancy was filled. She also covered caseload in the event of any absences, to assure each individual had an assigned RN Case Manager. The monitoring team specifically inquired about the frequency of MOSES and DISCUS training. The RN Case Manager reported that they were trained during orientation, but they did not receive an annual-refresher training for MOSES and DISCUS, which the monitoring team suggests. The RN Case Manager reported that all of the RN Nurse Case Managers were trained on the revised nursing guidelines for completing the nursing assessments, physical assessments, and nursing discharge summaries (CLDP). The RN Case Manager, since the last review, had incurred only one vacancy, where an RN Case Manager was promoted to the facility's IP. Discussions were ongoing with the CNE as to whether the vacancy will be filled. The monitoring team will follow-up on the next visit regarding the status of the rationale for not being able to fill the vacancy. <u>RN Case Managers Activities</u> • Review of Hospital/ER/LATC Forms • Review of Trigger Sheets • Develop and Implement IHCPs, staff instructions • Complete Admission/Annual/Quarterly Nursing Assessments • Complete Nursing Discharge Summaries CLDP • Attend Home Meetings • Attend ISPs, ISPA meetings • MOSES and DISCUS <u>New/Revised Guidelines</u> • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised 1/14 <u>Nursing Assessments</u> The monitoring team reviewed a sample of 24 Admission/Annual/Quarterly Nursing Assessments with dates between 1/15/14 and 6/26/14. The sample was selected from the facility's At Risk List identified as medium/high risk, for each of the homes/units completed by 10 RN Case Managers. The review used a monitoring tool comparable to the tool used by the LSSLC facility, and the revised Guidelines: Comprehensive Nursing /Quarterly Nursing Record Review /Quarterly Physical Assessments. The 16 individuals were Individual #235, Individual #204, Individual #59, Individual #134, Individual #228, Individual #539, Individual #357, Individual #313, Individual #365, Individual #586,	Noncompliance

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		Individual #109, Individual #181, Individual #368, Individual #129, Individual #556, and Individual #225. • 12 of 24 (50%) contained the required components of the assessments. Examples of missing documents were Individual #313 (physical assessment), Individual #331 (physical assessment), and Individual #109 (physical assessment). For those 12: • Three of three (100%) Admission Nursing Services Comprehensive were completed in accordance with the guidelines for meeting timelines. • Five of five (100%) Annual/Quarterly Nursing Assessments completed within 10 working days prior to the Annual ISP, in accordance with the guidelines. • Four of four (100%) Quarterly Nursing Assessments were completed by the last day of the month in which the quarterly assessment was due, in accordance with the guidelines. The monitoring team's overall score of 100% was similar to the facility's findings. The monitoring team's overall score assessment of 83% was lower than the facility's overall average of 92%. • 12 Admission/Annual/Quarterly Assessments were deficient for summaries/recommendations and did not sufficiently qualify for every problem/diagnosis, the data, by indicating progress toward the stated objectives/goals or the effectiveness of the health care plan. There were missed opportunities for documented suggested interventions to assist in guiding the IDT to achieve an outcome and/or address a health or mental health issue. One example was Individual #556, a 74 year old man, who had declined in health and was non-ambulatory and dependent on staff for all his needs. He required one-to-one supervision to keep him from pulling out his G-tube, and as indicated by the record, limited him the freedom to move his wheelchair as he desired. Recommendations did not include suggested interventions for any underlying problems that may be contributing to discomfort due to placement or positioning. The facility stated they had made progress in the timeliness of completing their assessments, but cited an overall noncompliance due to the need for more data to validate the nursing summaries. The monitoring team did not find substantial compliance. There was improvement noted for the 12 records reviewed in that the timelines were consistently being met. The nurse's need more time, experience, and training with the problematic aspects of the nursing summaries as identified above.	

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		The Nursing Department should ensure there are opportunities for training, that guide nurses in documenting substantial statements for actions taken to evaluate the individual's progress or lack of progress toward his or her goals.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	<u>Acute Care Plans</u> • Acute Care Plan Development, revised 12/13 The monitoring team reviewed the ACPs for Individual #109, Individual #46, Individual #129, Individual #235, Individual #556, Individual #357, Individual #586, Individual #539, Individual #365, and Individual #368 for 34 care plans. The plans of care were for the period of February 2014 through July 2014 for individuals that had acute care changes related to diagnosed infections, and/or skin integrity issues, and post-surgical procedures. The monitoring team found: • 31 of 34 (92%) were implemented within the timeline in accordance with the ACP guidelines. • 25 of 34 (74%) of the plans had baseline data that sufficiently described the issue for the implementation of the heath care plan. Individual #101 and Individual #586 had omissions for baseline data. • 34 of 34 (100%) of the plans contained the date that it was implemented. • 23 of 34 (68%) of the plans contained goals sufficient to identify the outcomes for their acute illness/injury The nursing care plans were problematic for: • Nursing and DSP interventions were not individualized. • Staff instructions were not written in terms that were clear and concise. For example, Individual #404's staff instruction, "inform nurse alternated level of consciousness" was not clear what observations were to be made in order to ascertain the altered level. • Plans were not consistently reviewed or resolved when the acute illness or injury had resolved. For example, Individual #404, Individual #556, and Individual #368's problems, identified in April 2014 and May 2014, had omissions for documenting reviews or applicable revisions or resolved date. • Acute care plans were not consistently documented in the same format. An example was Individual #357's care plan for respiratory failure that was entitled "Medical Care Plan" dated 6/27/14, and signed by nursing and medical. • Records contained ACP plans that were a year old (e.g., Individual #357).	Noncompliance

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		Nursing Discharge Summaries (CLDP) The monitoring team reviewed five CLDP Nursing Assessments for Individual #484, Individual #349, Individual #309, Individual #428, and Individual #311 and found: • One of five (20%) for each of the sections were complete. For example, Pain history for Individual #349 and Communication for Individual #484 were incomplete. • None of the four, (0%) records, documented the individual's preferences, strengths, and goals incorporated health. • One of the five (20%) included how the individual participated in his own health care. A positive example was Individual #349 participating in using hand sanitizer prior to eating. • Five of five (100%) nursing assessments were completed within the established time of the planned discharge date. • The majority of the CLDP recommendations failed to sufficiently address interventions to address all of the individual health problems and continuation for maintaining optimum health. This was seen for Individual #349. A positive example was Individual #309. Twenty-four seizure records, for the period of 4/8/14 through 7/13/14, were reviewed for Individual #225, Individual #357, and Individual #109. • 23 of 24 (96%) seizure records included the date, time, frequency, notification to the nurse, and whether or not the seizure was observed. • 18 of 24 (75%) record including nursing date, time, full vital signs, and the nurses signature and title. • 23 of 24 (96%) had a corresponding Nursing IPN note. Nine Trigger Sheets for the months of April 2014, May 2014, and June 2014 were reviewed for Individual #586, Individual #357, and Individual #556. • Nine of nine (100%) of the records reviewed contained blanks for documenting triggers • Nine of nine (100%) of the records reviewed contained blanks for the day, evening, and night shift for the required nursing review and initialing the documentation. • Trigger sheet instructions for the RN Case Manager was not specific for reviewing the documentation, thus, the reviews were not consistent and most occurred sporadically. • For Individual #556, documented the individual's respiratory difficulty on the 5/8/14 trigger sheet, and had corresponding DSP and a Nursing IPN note. It could not be discerned from most of the Trigger Sheets the meaning of the symbols o, *, or H as they were not part of the forms key.	

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		The facility self-rated they were not in substantial compliance. The monitoring team was in agreement. For the next six months the facility should: 1. Ensure there is nursing supervision and oversight to support nurses in developing substantial baseline statements, goals, and that interventions are individualized. 2. Ensure there is a system in place for tracking the status of implemented care plans.	
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.	The Nursing Department Assistant Nurse Educator was promoted to Director of Nurse Education when that position was vacated. The monitoring team met with the Assistant Nurse Educator and the accompanying Program Compliance RN to review and discuss medication observations that were problematic. The Assistant Nurse Educator stated that the medication passes skill check-off did not include both classroom and bedside competencies. The monitoring team, in addition, discussed the problems associated with administering medications via the enteral route. The monitoring team observed the Director for Nurse Educator orienting nurses in the classroom setting. Materials were present, along with the curriculum guide, and expected objectives for the training/education. <u>New/Revised Policies/Guidelines</u> • SSLC Nurse Competency Based Training Curriculum Guidelines, revised: 3/14 <u>Inservice on New/Revised/Reviewed Policies, Procedures, Protocols, and Guidelines</u> The facility's overall average for completed inservices was 91%. Areas that were below 91% that were in progress included: • Skin Care and Wound Prevention (74% nurses trained) • Tracheostomy Care (12% nurses trained)) • 2014 Skills Fair (Due 12/31/14, no percentage of number trained to date) • Peridex Application (75.5% completed) • Hospice Policy –updated (33% completed) • Medical Emergency Response Revised 1/16/14 (81.9% completed) • Temperature Log- revised, (86.2 % completed) • Skin Integrity Committee Policy (89.4%) <u>Training</u> • 14 nurses were hired from January 2014 through May 2014, • 14 of 14 (100%) of new nurses had completed new employee/nurse orientation	Noncompliance

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		• Nursing protocols were incorporated into new employee/nurse orientation <u>Implementation of Nursing Protocol Cards</u> The monitoring team reviewed the following records for compliance to the protocol cards that were used to guide nursing assessments and found: • Individual #556's DSP, on 6/17/14 at 12:20 am, reported that the individual had a nosebleed. The nurse assessed the individual for full vital signs, and reported that her interventions included holding the nares with pressure for 10 minutes. The record included staff instructions. The next available IPN note was 6/19/14. The record had an omission for any follow-up to the acute event. The record did not contain notification to the physician for the incident that required nursing intervention to stop the nosebleed or identifying the underlying cause. Even though the nose bleed may have been reported on a 24 hour report, continuity of care must be demonstrated in the active record. • On 7/10/14, it was documented that the Individual #109 was "moaning and groaning like he does when he is constipated." The protocol card Constipation was not fully implemented for assessing his bowel elimination patterns prior to the complaint. The individual also had an elevated temp 101.6, for which he received Tylenol. The pain and fever protocol were implemented on 7/10/14 and followed the frequency of required follow-up documentation for monitoring the temperature and pain. Even though the pain and fever protocol resulted in providing medication that relieved pain and reduced the fever, the physician should have been notified of the abdominal pain and fever because the underlying reason was unknown. The Nursing protocol for abdominal pain was not followed for reporting the individual's elevated temperature. • Individual #586, on 7/16/14 at 6:45 am, had drainage noted by staff when performing a treatment to his shoulder. On 7/17/14 at 1:00 pm, the Nursing IPN documented the individual's foot wound was noted to be draining. On 7/17/14 at 5:00 pm, the Nursing IPN documented a change in his foot that was described as was odorous, draining, and that measurements could not be taken because of the swelling of his toes. The Nursing IPN documented full vital signs and that a dressing change was completed. The Nursing IPN of 7/17/14 at 5 pm indicated the Nurse would make sure he was in rotation for sick call. Changes in drainage, presence of odor, and increased swelling can be signs and symptoms of infection that should have been reported promptly. Compliance was not found because Nursing assessments/protocols throughout this report, to varying degrees, did not consistently and sufficiently address the health status of the individuals. Records were problematic for incidents where there should have been	

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		physician notification. Furthermore, placing an individual on 24 hour report does not satisfy the requirements that the physician had timely knowledge of the individual's acute changes in status. In addition to making improvements to addressing the health status of individuals as noted above, the Nursing Department should ensure there are systems in place for timely notification to physicians, and that the notification is affirmed in the active record as part of the individual's continuity of care.	
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.	<u>Interdisciplinary Individual Support Team Meetings</u> The monitoring team attended one ISP meeting, for Individual #74. • All relevant IDT members, the individual, and the individual's invitee (volunteer) were in attendance at the meeting • The QIDP conducting the meeting ensured that the individual had opportunities for input to his ISP, and if he disagreed with proposed recommendations, that time was allotted for additional input or clarification. The QIDP also ensured, before moving to the next agenda item, that there was a resolution to any issue. • The RN Case Manager was present and, in many instances, offered current information about the individual's historical and current health problems. It was evident. • The QIDP guided a positive and productive meeting. • The monitoring team requested the individual record to review after the visit. The Annual Nursing Assessment required 10 days prior to the ISP was not present in the chart. From the list of available 12 Nursing Assessments in M2, the monitoring randomly selected three records, to review the Integrated Risk Rating Forms and the Integrated Health Care Plans. Individual #235, Individual #204, and Individual #228 each had one or more "high risks." Based on the review of the records, it appeared that the individuals' recognized or unrecognized risk were based on whether or not the individual had an incident and/or a result from a negative outcome. • For example, Individual #235 was rated high risk for all of Risk Group I, except constipation, for which the monitoring team disagreed. The IDT did not take into consideration that she was immobile, even though the facility used the term "bedbound," and that she was taking three medications on a daily basis, as well as one prn, for which the side effects included constipation. She was also prescribed three other medications to treat constipation. The record was problematic as the risk group recommendations included triggers for choking, aspiration, and constipation, which either the Trigger sheets were missing or did not exist.	Noncompliance

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		• Three of three (100%) IHCPs were developed and implemented within the 14 days required. However, from all the identified risk ratings, it could not be discerned that all plans had been implemented. • One of three (33%) contained preventive measures to lessen the identified risk ratings. • Two of three (66%) were adequately integrated among disciplines. • Two of three (66%) contained functional and measurable objectives in the ISP to measure efficacy for the plans • Individual #228's IRRF, dated 4/3/14, documented the risk rating as medium risk constipation. The section for documenting data discussion, analysis, risk rationale, triggers, and planning documented that he had mega colon. The IRRF did not include documentation that he was taking four medications that have side effects of constipation and was taking two medications to treat constipation. The monitoring team also attended an ISPA for Individual #235. During the meeting, there was discussion of transferring her from the Infirmary to another room. The monitoring team suggested the IP should assist regarding cohorting of individuals, based on the individuals' risks of infection. The team was in agreement with the monitoring team suggestion. The physician present talked about a plan to attempt weaning the individual from her tracheostomy. The facility should have policies and procedures that provide guidance and management for the process and necessary supports associated with de-cannulation. The monitoring team attended a section I meeting, where a database maintained by QA was discussed. This was valuable information that identified incidents, change of status, and heath care issues that reportedly were available to nursing staff. The CNE and NOO stated they were unaware of the available resource document. Databases, such as these, can be a useful tool when utilized. The monitoring team attended one of the Home Meetings on the unit. The meeting was held in the individuals' Day Room during the time individuals were engaged in their activities, such as watching TV. The Unit Manager chaired the meeting. Information was provided to staff regarding mandatory inservice documentation that required their reading and signature. It was not discerned if any of the required inservices contained information for immediate changes to policy or procedure. The Unit Manager reminded staff of the warm weather, and encouraged staff to offer fluids to individuals who did not have fluid restrictions. The RN Case Manager noted they were having water and water cups accessible for individuals in the day area. The Unit Manager noted he was continuing to follow-up on the request.	

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		The facility self-assessment indicated they were not in substantial compliance with M5. The monitoring team was in agreement. For the next six months, 1. The facility director should ensure there is ongoing evaluations to ascertain what is working and what is not working for having functioning systems in place for assessing and documenting clinical risk for each individual, and that plans and progress are integrated. 2. The facility should assure that the IDT, IRRF, and IHCP are effectively producing outcomes that guide the provision of health/mental care, and that interventions are based on potential and identified risks. 3. Nursing should ensure that IHCPs are in alignment with the individual's risk, interventions are realistic and measurable, and staff instructions that include observations are clear and concise. 4. The CNE and Residential Director should, in collaboration, ensure that there are ongoing opportunities for nursing to support the DSPs in effectively implementing their staff instructions and interventions that are required (e.g., trigger sheets, to ensure the individual's chronic health problems, such as constipation and skin integrity) are sufficiently being identified and addressed.	
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>Policies/Procedures/Guidelines</u> • SSLC Administration Guidelines, reviewed 1/14 • SSLC Enteral Medication Administration Nursing Protocol, revised 12/13 • Physical Nutritional Management Policy, revised 5/14 <u>Administration of Medications</u> The monitoring team observed medication administration for one home in each of the units: Individual #363, Individual #526, Individual #571, Individual #131, Individual #204, Individual #252, Individual #140, Individual #430, Individual #357, Individual #12, Individual #361, and Individual #218. The observations included oral, crushed with medications mixed with different mediums, such as applesauce, pudding, and thickened liquids, enteral, and topical medications. Eleven of 12 (91%) medication passes required <u>prompts</u> related to one or more of the essential items required on the facility's medication pass observation form, and other generally accepted professional standards of care. The omissions were as follows: • Nurse/staff identified individual prior to administration of medication • Nurse ensures the individual was in proper position prior to medication position for individual with an applicable plan • Performing the three quality checks • Confirmation form individuals that they had swallowed their medication	Noncompliance

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		• Oral medications were measured at eye level • Following all of the eight rights (right individual, right dose, right time, right texture, right position, right time, right reason, right route) • Provision of providing privacy • Pill crusher was cleaned per medication policy • General infection control practices were not adhered to and required prompts, regarding use of gloves, exchange of gloves, hand hygiene, cleaning of stethoscope between individuals Below is an example of a negative and a positive medication administration observations. • Of the medication pass observations, the most serious concern was for Individual #218, related to administration of enteral medications. The individual was found to have a residual over 100 cc, which required notification to the physician. The nurse proceeded (even after the prompt of the need to notify the physician per the plan) to force the plunger to give the individual liquid medication and 180 cc of water, following which gastric fluids immediately exploded back on the individual and the nurse. The individual's PNMP plan was not followed for positioning, even with prompts. The incident was reported to the CNE, the nurse was removed from administering medications, and corrective action plan was put in place. • For the passing of medication for Individual #571, the nurse demonstrated proficiency in administering the medication, and it was positive to observe the interaction between the nurse, the individual, and the accompanying DSP staff. This observation included oral medications, and followed the PNMP plan. <u>Documentation</u> The facility's Medication Administration Policy cited "results from PRN medications are documented on the back on the reverse side of the MAR." For the medication records reviewed in this section, documentation of medications for PRNs could not be evaluated for compliance due to the missing reverse pages. <u>Storage and Security of Drugs</u> The monitoring team conducted focused reviews for inspection of medication rooms and stock medications and found: • Infirmary medication carts were found unlocked and unattended • Two bottles of Pro-Stat were unattended at the nursing station • Staff personal medication was found unsecured on a unit • Medication was open and not dated, for example Individual #313 • PPD injectable was opened and not dated in home #559	

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		Oversight and Monitoring The facility had revised its Refrigerator Temperature Log form to include the parameters for reporting, and a section for actions and comments. The Nursing Department had also implemented performance counseling statements for when the protocol for monitoring the refrigerator temperature was not followed. The monitoring team found evidence of this with the associated refrigerator temperature logs submitted. The monitoring team reviewed June 2014 Refrigerator logs for the 10 areas with refrigerators in the medication rooms. • Eight of 10 (80%) did not contain blanks for documenting the temperature. • Four of four (100%) that identified problems with the refrigerator had a corresponding actions and evidence the reported problems were reported. The facility Glucometer Control Sheets were found completed monthly and without blanks. A focused review of the Strips for measuring High Range and the result were found without blanks and within the manufacture's required range. Medication Variance Meetings/Medication Variances The monitoring team attended the facility Medication Variance Meeting. The facility was in the process of following-up on previous recommendation made by the monitoring team for systems to be in place for check and balances for their medication program. The facility presented a new form that they planned to implement to address the recommendation. A review of the data presented in the meeting for medication variances found more work was needed toward an integrated process that includes nursing, medical, and pharmacy in the review of medication variances. The monitoring team will follow-up at the next visit for system changes made for improvements to having sufficient check and balances, and integrated systems that review medication variances. The monitoring team reviewed 10 of the most recent Medication Variances and plan of correction for Individual #413, Individual #126, Individual #228, Individual #316, Individual #213, Individual #370, Individual #108, Individual #232, Individual #114, and Individual #500 and found: • Four of 10 (40%) Medication Variance Reports were completed for all applicable items on the report form A through N. Eight of 10 (80%) of the medication variances were committed by nurses. Four of the eight medication variances were jointly committed by pharmacy, for a total of five for pharmacy. One was documented in the category of other. • Six of eight (75%) of the nursing medication variances, the individual received either an extra dose or the wrong dose. The other two were documented as an omission and wrong patient.	

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		• Medication Variance for Individual #370 indicated a systems problem regarding receipt and documentation of medication on the sheet for controlled medications. Corrective actions documented that all nurses were inserviced as a result of the identified problem. See section N8 for additional information on medication variances The facility's self- assessment indicated they were in substantial compliance. Even through the facility was working toward improvement in its systems, there was not sufficient evidence that the facility had sufficient checks and balances in place for having a medication safety system. Going forward, for the next six months, 1. The facility should ensure there are integrated, standardized process/procedures for nursing, medical and pharmacy to sufficiently review, measure, and study their medication variances. 2. The Nursing Department should ensure that Nurses have sufficient opportunities in the classroom and at the bedside to sufficiently assure they are consistently and with confidence following acceptable standards of practice for administration and infection control. 3. Nursing Department should re-evaluate the training/education classroom and bedside competencies for nurses. 4. The Nursing Department should ensure that Nurses have sufficient opportunities in the classroom, and at the bedside to sufficiently assure acceptable standards of practice, and that there is feedback from the nurse, that he/she has achieved a level of confidence/comfort in mastering administering medications by the different routes and plans put in place for medication safety.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, 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 Pharmacy and Therapeutics Committee Meeting Minutes, 2014 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 #484, Individual #215 Individual #134, Individual #411, Individual #357 Individual #119 Individual #506, Individual #574, Individual #547 Individual #159, Individual #471, Individual #383, Individual #562, Individual #189, Individual #108 Individual #502, Individual #382, Individual #299, Individual #59 Individual #337, Individual #170 Individual #450 Individual #121 o MOSES and/or DISCUS Evaluations for the following individuals: • Individual #582, Individual #121, Individual #542, Individual #383, Individual #424, Individual #545, Individual #88, Individual #365, Individual #507 Individual #466, Individual #574, Individual #354, Individual #395, Individual #28, Individual #450, Individual #413, Individual #66, Individual #59, Individual #502, Individual #450 • Individual #170, Individual #337, Individual #121, Individual #299, Individual #517, Individual #382, Individual #357

	Interviews and Meetings Held: o David Leeves, RPh, Pharmacy Director o Janet Noteware, PharmD, Clinical 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 did an adequate job in metric selection, but the use of the metrics was questionable. For example, for provision N3, the self-assessment noted that the metabolic syndrome risk was addressed. However, it was well documented that the QDRR form required revision because the metabolic syndrome was not adequately addressed. Moreover, section N2 noted that only 43% of QDRRs included the required labs. 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, and N7. It found itself in noncompliance with N2, N5, N6, and N8. The monitoring team found the facility in substantial compliance with provision item N4. The monitoring team found the facility in noncompliance with provision items N1, N2, N3, N5, N6, N7, and N8.
	Summary of Monitor's Assessment: There was very little progress noted in the provision of pharmacy services. In fact, regression was seen in a number of areas. A new clinical pharmacist began working at the facility on 5/6/14. She was familiar with the facility because she had worked part-time since November 2013. She encountered quite a few challenges because over the past years, the pharmacy department had not made a great deal of progress. There was documentation of communication between the prescribers and pharmacists, but it was minimal

	given the facility's census. The pharmacists failed to document the conclusions for a number of events. It also appeared that the pharmacy director was the only pharmacist who was documenting communication. The number of entries by the staff pharmacist who was responsible for dispensing medications was minimal. There was a continued need to develop a process for managing drug interactions. Completion of QDRRs improved in terms of timeliness, but the content needed significant improvement. The QDRRs failed to adequately address many clinical issues, such as diabetes mellitus, hypertension, and the monitoring for endocrine risks, such as metabolic syndrome. Problems with the content of the QDRRs included missed opportunities to make recommendations related to care. For those recommendations that were made, the prescribers usually agreed. When they did not agree, they provided ample explanation for the disagreement. This was an improvement since the last review. Electronic completion of the MOSES and DISCUS evaluations did not appear to improve the process. In fact, it seemed to serve as a barrier to proper completion of the evaluations. The AVATAR system was fully functional and had the ability to allow for completion of the evaluations. The MOSES evaluations frequently did not include the required prescriber review. The DISCUS evaluations were usually properly completed. Unfortunately, the evaluations were not used by the neurology consultants or PCPs. The facility reported only four ADRs since the last compliance review even though examples of ADRs were seen in the records, consults, and other documents. Documentation for the facility's ADR reporting and monitoring system was not adequate. Only one DUE was completed since the last compliance review. Quarterly DUEs were required. Overall, there was a failure to comply with the requirements for completion of DUEs as required in policy and procedure. The facility continued to report medication variances. A number of process changes were implemented in order to address medication variances. The facility was in the process of assessing and revising some processes that proved to be ineffective. A major concern with the medication variance system was the continued lack of physician participation. The role of prescribing in preventable medication errors is well documented. A functional medication variance committee requires the active participation by a member of the medical staff. The pharmacy department appeared to be impacted by poor organization. The monitoring team requested a copy of all policies and procedures prior to the compliance review. The document submission provided no information. Even when a request was made to view policies and procedures onsite, no policy and procedure manual was available. When the information was provided, the monitoring team noticed that policies and procedures provided during previous visits were not included. Moreover, pharmacy policies were not being reviewed and updated. That lack of effective management was impacting many aspects of pharmacy services. The pharmacy department has had a series of clinical pharmacists over the past two years. The current clinical pharmacist began working full time in May 2014. Discussions that occurred during the week of the compliance review indicated that she had not been provided adequate support. She was unaware of many

	key requirements related to the Settlement Agreement. She did not have current policies and procedures and when attempting to retrieve information electronically, did not have access to that information. Timelines for completion of critical tasks had not been discussed and were, therefore, overlooked. Similar issues were identified during previous visits with newly hired clinical pharmacists. The facility will not make progress in this provision or be capable of providing the appropriate pharmacy services if the clinical pharmacist responsible for many important processes, such as ADRs, DUEs, and QDRRs is not provided the proper guidance. All of these processes play a vital role in ensuring medication safety. Facility management must take the necessary actions to ensure that guidance and support are provided.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	This provision item is related to fundamental components of the medication use system – the prescribing and dispensing of medications. The pharmacy department completed prospective reviews for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues. The pharmacy director reported that all communication between pharmacists and prescribers was now documented in WORx. The facility provided two documents as evidence of communication between pharmacist and prescribers: Single Patient Interventions and Notes Extracts –COMM/CLIN. Single Patient Interventions – Following removal of duplicate entries, seven interventions were documented from January 2014 – May 2014. The documentation provided was minimal. The drug involved was listed along with one brief comment or recommendation. Two of the seven interventions documented the response of the provider or the action taken to resolve the issue. The following are examples of the interventions reviewed: • Individual #382, 1/1/14: A drug interaction with propranolol was identified. However, the documentation did not indicate the other drug(s). There was no resolution documented. • Individual #555, 2/13/14: The intervention stated, "may need to adjust dose of tramadol due to sertraline. The response of the provider was not documented. • Individual #382, 3/19/14: It was documented that the medical LVN was called about increased serotonin levels with use of Linezolid. The PCP advised to go ahead with the antibiotic and monitor for serotonin syndrome. • Individual #556, 3/13/14: The recommendation was to titrate off metoclopramide due to the increased risk of tardive dyskinesia. The titration started that day. • Individual #118, 4/22/14: The individual was allergic to Augmentin and was prescribed ampicillin. The recommendation was to monitor for rash or allergic	Noncompliance

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		reaction. The resolution was not documented. The appropriateness of the management of the problems reported above could not be determined. The level of the drug interactions was not specified and there was no documentation of the physician response and/or resolution. Individual #118 was reported to be allergic to Augmentin. Ampicillin is in the same penicillin class as Augmentin. A true penicillin allergy would be a contraindication for the use of ampicillin. Dispensing the drug with a recommendation to monitor for an allergic reaction would not be compatible with safe pharmacy practices. In addition to the concerns with the quality of documentation, the monitoring team found it odd that all SPIs were documented by the pharmacy director. The facility had a full time staff pharmacist whose primary job was medication dispensing. The Notes Extracts were used to document order clarifications and other communication. Fifty-six order clarifications were documented. Order clarification included issues related to frequency of administration, dose, and indications. Many order clarifications were reported as medication variances. Some of those issues were not true variances. For example, physicians do not typically write a specific amount or ounces of shampoo that should be utilized for an individual. Similar to what was observed with the SPI documentation, nearly all entries included the initials of the pharmacy director. Very few were made by the full time staff pharmacist. It would be expected that a full time pharmacist who is dispensing medications would have more opportunities to document interventions and communication than the pharmacy director. The clinical services director should conduct further review of this finding. Seventeen events were logged for the Notes Extract- COMM including: • Consultation with PCP • Changing time for vitamin and calcium administration • Monitoring blood pressure with use of two beta blockers • Prolactin increased due to Risperdal The documentation submitted provided little communication for a facility with a census of 328. Many individuals had multiple medical problems and received numerous high-risk medications. There was very little documentation of drug interactions and this was an unusual finding because drug interactions are typically documented in the Notes Extracts. During previous reviews, the monitoring team was informed by the pharmacy director that the pharmacist used common sense in determining when to notify a physician of drug interactions. A recommendation was made by the monitoring team to develop a procedure for management of all drug interactions. Moreover, it was	

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		recommended that severe drug interactions require direct communication with the prescriber and written information should be provided in the form of the drug monographs. The documentation submitted did not describe the level of the drug interaction. There was also no documentation of any drug monographs being provided to the PCPs. 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." The pharmacy director reported no problems with the use of the Intelligent Alerts Module. Entries were made for 219 medication orders. It was reported that 100% of orders written had the appropriate lab monitoring. Yet, record and document reviews indicated that there were problems with some aspects of medication laboratory monitoring. The pharmacy director should ensure that he is appropriately assessing the use of the Intelligent Alerts Module and verify that 100% of all new physician orders have laboratory monitoring consistent with protocols. The pharmacy department lacked policy guidance for some aspects of this provision. The pharmacy services policy was dated December 2013. It did not include any information on the process for the Intelligent Alerts or the drugs that were monitored. That information was not found in any of the policies and procedures submitted by the department. Overall, the documentation provided for the review period was less consistent than that seen in the last compliance review. There were seven clinical interventions and most did not include an outcome. The lack of documentation of drug interactions was particularly disturbing because it indicated that the medical staff may not have received the appropriate notification of drug interactions because this was left to the discretion of the pharmacist. <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 documentation of communication with prescribers should be increased. There should be clear documentation of the prescriber who is contacted and the time of contact. 2. The procedure for management of <u>all drug interactions</u> should be clearly	

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		delineated. Severe drug interactions should require direct communication with the prescriber and written information should be provided in the form of the drug monographs. 3. The pharmacy director must ensure that the Intelligent Alerts module is being utilized correctly and in accordance with state issued guidelines. Reports should be printed on a regular basis and the data reviewed with the medical director. 4. The clinical services director should ensure that all policies and procedures are current and reflect current requirements and practices.	
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.	A total of 29 Quarterly Drug Regimen Reviews was evaluated to determine compliance with this provision item. In accordance with state policy, the QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential. Compliance with timely completion for the months of January 2014 to May 2014 was 73%. This was based on the QDRRs being completed during the assigned month. The clinical pharmacist used the schedule that was developed by the previous clinical pharmacist. She was not aware of the specific timelines for completion as mandated by state office. That information had not been provided to her. While the compliance with timely completion of QDRRs improved since the last review, there were a number of concerns related to the clinical relevance and content of the evaluations. The following are some of the problems observed: • The clinical pharmacist was not always using the most recent data. Several documents reported labs from mid-2013 when data were available for 2014. It appeared that the labs from the previous QDRR were not updated. • Labs and diagnostics were bulleted on the first page of the report. There was no association between the labs and drugs that were monitored. Some lab values had no relevance for the drugs that were monitored. • Diagnostics were usually provided with limited information. For example, indicating that an EKG was "abnormal," without providing information that is more specific, was not particularly useful. EKGs were noted to be overdue, but no recommendation to obtain a current EKG was made. • Consults were listed, but no information from the consults was included. The pharmacist generally noted vision consult – return to clinic… • There was little, if any, commentary on abnormal lab values and diagnostics. The data were simply listed. Some of the abnormalities required attention. • Monitoring parameters for conditions, such as hypertension and diabetes, were not provided.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• There were no comments regarding metabolic syndrome risks. A box was checked indicating that it was monitored, but no additional statements were made. QDRRs sometimes included the labs. As already noted, the data were listed, but there were no comments, even if the lab values were abnormal. Not all of the criteria needed for review of metabolic syndrome were documented. Abdominal girth was not included in any of the documents and glucose levels were frequently not found. There was no overall statement about the individual's risk. • Several individuals with poor renal function were reviewed. The clinical pharmacist noted that the creatinine clearance was low, but provided no guidance related to renal dosing of medications. • Lab values were documented by exception or incomplete labs were provided. In several instances, a serum creatinine was listed from the BMP, but other values were not. Thus, for an individual who received diuretics, there was no documentation of electrolytes. Individuals who received topiramate did not have the CO2 documented, which is needed for monitoring for the development of metabolic acidosis. 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 are some specific examples of the concerns noted above: • Individual #484, 5/11/14: There was no recommendation for an abnormal HbA1c of 5.9. The last EKG was reported as 4/13, but there was no recommendation to obtain the annual EKG required for psychotropic medication monitoring. • Individual #215, 5/6/14: This individual was treated with clonidine for hypertension. Monitoring parameters, such as blood pressure, urine albumin, and serum creatinine were not documented. There was no comment regarding the abnormal HbA1c of 5.8. The individual also had elevated triglycerides. There was no abdominal girth documented. The individual should be evaluated for metabolic syndrome. The last EKG was documented as 3/13. Annual EKGs are required due to the diagnosis of hypertension. • Individual #424, 5/6/14: This individual received multiple medications for treatment of hypertension and had a CrCl of 40 ml/min. There was no documentation of blood pressure control. There was also no discussion regarding the need to adjust medications due to chronic kidney disease. • Individual #119, 4/1/14: There was no documentation of the monitoring parameters for diabetes mellitus, such as urinary protein, eye exam, etc. • Individual #506, 4/1/14: The individual received propranolol for hypertension and tachycardia. There was no documentation of the effectiveness of treatment.	

#	Provision	Assessment of Status	Compliance
		The blood pressure and heart rate ranges were not documented. • Individual #471, 5/7/14: The clinical pharmacist recommended that iron supplements be provided for anemia, but there was no evidence of iron deficiency documented. • Individual #562, 5/11/14: The last EKG was noted to be done in 2012. The individual required annual EKGs due to psychotropic drug use. There was also no documentation of the eye exam required for use with quetiapine. • Individual #189, 5/10/14: The individual received HCTZ and propranolol for management of hypertension. There was no documentation of serum potassium or urinary protein. There was no comment related to the abnormal HbA1c of 6.1 Some of problems observed in the QDRRs had already been identified by facility audits. The self-assessment documented that 43% of the sample audited included the required lab and diagnostics. The clinical pharmacist drafted a QDRR form revision adding prompts related to metabolic syndrome and monitoring parameters related to hypertension. The presentation book included samples of data collection notes. The pharmacist simply wrote various data elements at the bottom of the drug profile for each individual. It appeared that the worksheet, which was used at other SSLCs, was not utilized here. The previous clinical pharmacist elected to stop using the worksheet and this was noted during the previous compliance review. The use of the worksheet appeared instrumental in ensuring that all of the required components were completed for each QDRR. The monitoring team needs to emphasize that providing a series of data elements is not the intent of the QDRR. The evaluation needs to link those data elements to the medication use. It may be helpful to organize the comments by the conditions for which the medications are prescribed or by drugs that require monitoring. For example, if quetiapine was prescribed, the clinical pharmacist would then list the required monitoring parameters and the status of each making comments about any abnormalities that are noted. Several SSLCs have created various formats for achieving this goal. The monitoring team encourages the clinical pharmacist to seek guidance from the state pharmacy services coordinator. The timeliness of completion of QDRRs was much improved, but remained at an unacceptable level. Moreover, the content of the QDRRs will need to improve significantly in order for the documents to provide accurate and clinically relevant information. <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:	

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		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.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs. Benzodiazepines used were listed along with the indication. The findings of the MOSES and DISCUS evaluations were sometimes noted as well. The use of prn meds/chemical restraints is discussed further in section J. <u>Polypharmacy</u> Psychotropic and non-psychotropic medication polypharmacy was addressed in the QDRRs reviewed. The monitoring team attended the Polypharmacy Oversight Committee meeting during the week of the review. The committee was chaired by the clinical pharmacist. Psychotropic polypharmacy is discussed in detail in section J11. <u>Anticholinergic Monitoring</u> Each of the QDRRs commented on the anticholinergic burden associated with drug use. A score was assigned for the total burden. The pharmacist occasionally commented on plans to address the ACB. <u>Monitoring Metabolic and Endocrine Risk</u> The primary mechanism for monitoring metabolic syndrome was through the QDRRs. As discussed in section N2, the QDRRs failed to adequately address metabolic syndrome. Criteria, such as abdominal girth, were not recorded and serum glucoses were frequently not documented. None of the QDRRs reviewed provided any comments on metabolic syndrome. Even when the appropriate labs were listed, the clinical pharmacist did not use the information to make a determination or statement regarding the risk of developing metabolic syndrome. As a result of this, the facility may fail to detect individuals with this syndrome. The medical compliance coordinator reported that eight individuals were diagnosed with metabolic syndrome. The CDC estimates that approximately 34% of the population 20 years of age and over meets the criteria for metabolic syndrome. Based on the information provided, 2.5% of the population at LSSLC was reported to have metabolic syndrome.	Noncompliance

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		A substantial number of individuals had abnormal HbA1c levels documented in the QDRRs and active records. These individuals did not meet the threshold to be diagnosed with diabetes mellitus. The American Diabetes Association considers individuals with an A1C range of 5.7–6.4% as having prediabetes and being at high risk for the future development of diabetes mellitus. It is important to implement the appropriate interventions at this stage to lower the risk of developing diabetes mellitus. The clinical pharmacist recognized that this important health issue was not adequately assessed in the QDRRs. Consequently, a QDRR form revision was proposed. Approval of the template revision was pending at the time of the compliance review. Information on metabolic syndrome was included in the presentation book. It was noted that the source was Wikipedia. The monitoring team discourages the use of user-generated web sites for the purpose of formulating guidelines, policies, and procedures. There are a number of credible sources that can be used for this purpose. <u>Compliance Rating and Recommendations</u> This provision remained in substantial compliance during the last review. Continued substantial compliance was contingent upon the facility taking actions to ensure that individuals at risk were identified, appropriately assessed and when necessary interventions implemented. There was no evidence that those actions occurred in a satisfactory manner. This provision is determined to be in noncompliance. To move towards substantial compliance, the facility must address the issue of monitoring for the metabolic syndrome as discussed above. Individuals with pre-diabetes should also be identified.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the providers' responses to both <u>prospective and retrospective reviews</u>. The facility has continued to only assess the providers' response to the QDRRs even though the monitoring team has clearly indicated that the provision addressed the response to prospective and retrospective recommendations. <u>Prospective Recommendations</u> Prospective recommendations were generated at the time new orders were written. The recommendations were documented in the Single Patient Interventions and Notes Extracts. The outcome of the discussions between the pharmacists and prescribers was not always clear. The monitoring team had little information to assess the physicians response to prospective orders.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Retrospective Recommendations The clinical pharmacists also made formal recommendations when completing the QDRRs. Psychiatry was required to review the QDRRs when the individual received psychotropic medications. As noted in section N2, the clinical pharmacist missed many opportunities to make recommendations. Thus, the number of recommendations made in the QDRRs reviewed was relatively small. When recommendations were made, the prescribers usually accepted those recommendations indicating what actions would be taken. When prescribers disagreed with the recommendations, they generally provided explanations on the form. Compliance Rating and Recommendations The monitoring team agrees with the facility's rating of substantial compliance. In order to maintain substantial compliance, the facility must address the deficit of documentation of prospective orders.	
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 10 MOSES and 11 DISCUS evaluations. The most recent evaluations included in the record sample were also reviewed. The findings are summarized below: Sixteen MOSES evaluations were reviewed for timeliness and completion: • 12 of 16 (75%) evaluations were signed and dated by the prescriber • 5 of 16 (31%) evaluations indicated no action necessary • 6 of 16 (37%) evaluations had no prescriber review (blank) • 4 of 16 (25%) evaluations included a statement such as "see dictated note" or "reviewed" • 1 of 16 (6%) evaluations did not include a second page Fourteen DISCUS evaluations were reviewed for timeliness and completion: • 14 of 14 (100%) evaluations were signed and dated by the prescriber	Noncompliance

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		• 1 of 14 (7%) evaluations had no prescriber review (blank) • 10 of 14 (71%) evaluations documented no TD • 3 of 14 (21%) evaluations documented TD The evaluations were completed electronically via AVATAR. The medical staff had the ability to complete the prescriber review electronically. The majority of the MOSES evaluations lacked the prescriber review, however, the DISCUS evaluations did not. The sample submitted by the facility indicated prompt review by the prescribers. Significant delays in prescriber review were noted in the documents found in the record sample. The monitoring team has continually stressed the importance of utilizing the information obtained from the side effects rating tools. The evaluations were a valuable source of information regarding medication side effects. The information captured by the rating instruments had the ability to impact treatment decisions. The assessments also often provided evidence of potential ADRs. It has been specifically recommended that the neurology consultant and PCPs review this information. During discussions with the neurology consultant, he informed the monitoring team that he was not familiar with the MOSES ad DISCUS forms and had never been asked by facility staff to review the documents. <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. 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	The facility made little progress in monitoring and reporting ADRs. A chart listing ADRs reported over the past year was submitted. The chart included eight ADRs, but did not provide the date that the reactions occurred or were reported. The ADR report forms were also reviewed. Based on that data, four ADRs were reported since the last compliance review, all of which were reported in May 2014. Per the self-assessment, ADRs reported between 1/1/14 and 5/30/14 were presented in	Noncompliance

#	Provision	Assessment of Status	Compliance
	adverse drug reactions.	the January 2014 and April 2014 meetings. A total of six ADRs were discussed. It was not clear to the monitoring team how ADRs reported in May 2014 could have been discussed in the April 2014 meeting. There was no documentation in the P&T minutes for the four ADRs that occurred in May 2014. Minutes from the April 2014 Pharmacy and Therapeutics Committee meeting documented that one ADR was discussed. That reaction did not appear in the summary data even though the PCP stated that the individual should be labeled as allergic to the medication. Overall, this system was poorly organized and did not appear to capture the relatively few ADRs that were reported. The summary data provided little information. The clinical pharmacist acknowledged that there was a problem with under-reporting. There were numerous ADRs seen in records that failed to be reported. Elevated prolactin levels, thrombocytopenia, and other blood dyscrasias were frequently seen. The consult reports reviewed often noted blood dyscrasia and the consultant attributed the abnormalities to medications. Multiple individuals had renal stones that were potentially linked to use of topiramate. The clinical pharmacist believed training would address the lack of reporting. To that end, training tools were developed in order to provide training in new employee orientation, nursing orientation. A training schedule for the direct care professionals was developed. The ADR policy was in he process of being revised. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-assessment rating of noncompliance for this provision item. Overall, LSSLC did not maintain an adequate system for monitoring and reporting ADRs. The number of ADRs reported was relatively 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,	

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		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 severity threshold. The criteria for review should ensure that cases are appropriately reviewed in a timely manner and the findings formally presented to the Pharmacy and Therapeutics Committee.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility completed one DUE since the last compliance review. A DUE on treatment of osteoporosis was presented at the P&T Committee meeting on 4/23/14. The monitoring team reviewed the DUE report. According to the DUE report, the objective was to assure appropriateness, safety, and effectiveness of the use of medications for osteoporosis. Criteria included the number of individuals who received osteoporosis medications and the number of individuals who received concomitant treatment with PPIs and antacids. The study was conducted by reviewing the medication profiles for all individuals who received the medications. The report documented the conclusion, which was the number of individuals who received each osteoporosis medication in addition to the number of individuals who received osteoporosis medications, and PPIs or antacids. No other data were reported. It was not clear from the report how the criteria selected assisted in determining appropriateness or safety of treatment. Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. In that respect, the selected metrics did not appear valid. A number of other metrics would have been better measures of effectiveness and appropriateness of therapy. For example, BMD scores are used to monitor the effectiveness of therapy. Per the DUE policy, the P&T Committee shall approve the data collection form, which specifies the indicators to be evaluated, the thresholds of compliance, DUE dates, and sample size. The report should include length of time of study, nature of study (prospective, retrospective), and method of data evaluation. Discussions with the clinical pharmacist, pharmacy director, and clinical services director revealed that the DUE calendar was altered by the clinical pharmacist without approval by the P&T committee. The committee was not involved in the development of the metrics that were utilized. As a result of this, a DUE was conducted that did not appear to provide a great deal of information that had the ability to impact the care of the individuals.	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>Overall, the facility did not meet the requirements to conduct DUEs. In order to meet requirements for completion of quarterly DUEs, the next DUE needed to be completed by the end of July 2014. At the time of the compliance review, the P&T committee had not approved the next DUE and, therefore, no tools or metrics were selected. In addition to meeting requirements for timelines, additional work was needed to improve the quality of the content of 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.
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.</td><td></td></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="7">Medication Variances 2014</th></tr>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th></tr>
<tr><td>Nursing</td><td>102</td><td>27</td><td>13</td><td>49</td><td>47</td><td>25</td></tr>
<tr><td>Pharmacy</td><td>3</td><td>3</td><td>4</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>Medical</td><td>11</td><td>1</td><td>6</td><td>12</td><td>9</td><td>22</td></tr>
</table>

The majority of prescriber variances were related to missing diagnosis. Several prescribing errors were characterized as "PCP error writing order." By definition, prescribing errors are errors in order writing. The facility will need to better define the <u>type</u> of prescribing errors. It was a positive finding that the facility recognized the need to report prescribing errors. The largest number of nursing errors was related to documentation – the MARs were missing initials. Wrong dose and wrong medication errors continued to be documented. Pharmacy errors had decreased in recent months. The pharmacy director reported most errors were caught before the medications actually left the pharmacy.</td><td>Noncompliance</td></tr>
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		The monitoring team attended the Medication Variance Committee meeting. Nursing reported that problems related to transcription continued to be a significant factor in the number of variances. Twenty-four-hour chart checks were limited to the infirmary. In order to ensure that medication orders were transcribed in a timely manner, the facility implemented a process in which individuals seen on sick call were documented in a log. Each unit was responsible for checking the log every shift to ensure that orders were transcribed. The CNE reported that the process was not working very well because it had been limited to the primary care clinics. Orders were also being written in psychiatry and skin integrity clinics. Nursing management had recently met with staff from both clinics as well as the four medical LVNs to review the process. The monitoring team noted that the facility continued to assess outcomes associated with variances. When errors involved AEDs, the minutes documented that the seizure frequency was reviewed. A similar approach was used when psychotropic medications were involved. However, the process was not occurring for some other high-risk drugs. An individual was reported to have missed antihypertensive medication. The monitoring team inquired about the length of the variance and the status of the individual. It appeared that information was not readily available. Even though a number of corrective actions were implemented to address medication variances, several issues will need to be addressed to move toward substantial compliance: • Variances continued to be counted as single event even when they occurred over a span of time. Thus, the monitoring team noted that the data as presented did not provide adequate information about the magnitude of the variances. • Each clinical discipline was responsible for assigning the category of variance and reporting data to the committee. This process resulted in little oversight and a lack of checks and balances for the system. A multi-disciplinary review should occur. • The reporting of prescribing errors remained problematic. The category of "order writing error" was very vague. Additionally, there was no active physician participation in the facility's medication variance system. Meeting minutes documented that the locum tenens physician was present for one meeting since the last compliance review. The management and discussion of medication variances is a clinical issue that requires the content expertise of a physician. Likewise, medication variances that involve clinical issues, such as wrong doses and wrong medications should be reviewed by the medical director and physicians involved. There was no documentation that this occurred. Medical meetings indicated that the clinical services director was reviewing medication	

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		errors with staff. • At the time of the compliance review, the CNE acknowledged that the process changes related to transcription had not been effective and corrective actions had been recently implemented. <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 monitoring team recommends that the facility address the outstanding issues noted in the text. The facility must also continue to work on medication reconciliation and demonstrate that all non-pill medications are reconciled.	

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 QA Reports o PNM Data Reports/Monthly Reviews o PNM spreadsheets submitted o PNMT Evaluation template o PNMT Assessment Audit tools o PNMT Meeting documentation submitted o Daily Provider Meeting minutes o Pneumonia Committee 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 and documentation for the following: Individual #336, Individual #542, Individual #306, and Individual #560. o PNM spreadsheets o Individuals with PNM Needs o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Annual Refresher curriculum materials related to PNM o Documentation of staff training submitted 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 List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30

	○ Individuals with Fractures ○ Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months ○ Individuals With Falls Past 6 Months ○ List of Individuals with Chronic Respiratory Infections ○ List of Individuals with Enteral Nutrition ○ Individuals with Chronic Dehydration ○ List of Individuals with Fecal Impaction ○ Individuals Who Require Mealtime Assistance ○ List of Choking Events in the Last 12 Months ○ Individuals with Pressure Ulcers and Skin Breakdown ○ Individuals with Fractures Past 12 Months ○ Individuals who were non-ambulatory or require assisted ambulation ○ APEN Evaluations for Individual #33, Individual #368, Individual #515, Individual #172, Individual #542, Individual #112, Individual #518, Individual #357, Individual #47, and Individual #586. ○ PNMT Assessments and ISPs submitted for Individual #101, Individual #203, and Individual #240. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. ○ PNMP section in Individual Notebooks for the following: • Individual #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. <u>Interviews and Meetings Held</u>: ○ Danielle Perry, AuD, CCC-A, Habilitation Therapies Director ○ April Mettlen, RN

	○ Carrie Flowers, RD, LD ○ Vickie McCarley, MS, CCC-SLP ○ Nicholas Coco, OTR ○ Cristen Nerren, PT, DPT ○ Dalisa Smiley, PNMPC ○ Gale Wasson, Facility Director ○ Mary Bowers ○ Various supervisors and direct support staff <u>Observations Conducted</u>: ○ Living areas ○ Dining rooms ○ Day programs ○ PNMT meeting ○ Pneumonia Committee meeting ○ Section I meeting
	Facility Self-Assessment: The self-assessment completed by Danielle Perry, AuD, CCC-A, Habilitation Therapies Director, was the best to date. The assessment was clear with relevant activities conducted. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently 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. Continued progress was noted, but improvements were still needed in the areas of quality and timeliness of assessments, monitoring, and direct intervention. The department leadership appeared on track with a plan to ensure that continued progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself not in substantial compliance with provisions 0.1 through 0.8 and the monitoring team concurred. In order 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 adequate participation by medical providers in the process of PNMT assessment and review. This may involve review of assessments, attendance at meetings, attendance at IDT meetings in which the provider also attends, improved representation at facility meetings in which interaction would be promoted. These methods should be easily documented and tracked. 2. The PNMT should consider initial meetings with the IDT for individuals who were to be assessed

	by the team, in order to plan the assessment process and establish outcomes and exit criteria. The PNMT should continue meeting with the IDT to introduce the assessment findings and develop an intervention plan. Further, at the time of discharge, the PNMT should also meet with the IDT to ensure that outstanding actions were attended to and that all supports and interventions were clearly integrated into the ISP and IHCP. The teams should determine what, if any, level of continued follow-up was indicated. 3. Consider revision of the current meeting minute format to ensure that action steps, person(s) responsible, due dates, as well as, key clinician indicators, measurable outcomes and exit criteria were tracked at the time of each review to determine the individual's status. 4. Ensure that referrals are initiated by the IDT and/or PNMT in timely manner so that the assessments are conducted in a timely manner that reflects the urgency of the identified PNM needs. 5. Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. 6. Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly, succinctly, and in a timely manner. 7. Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in an ISPA meeting. 8. Consider a recommendation log to readily track completion of action steps. 9. Clarification of the staff who had successfully completed all competency-based training was needed. 10. Develop a clear system to ensure that staff responsible for training others were competent to do so (NEO and Annual Refresher training) 11. The facility should ensure that the Mealtime Coordinator position is adequately implemented across all homes for all meals. 12. Continue drills related to staff understanding risks and the rationale for PNM strategies contained in the PNMPs and Dining plans. 13. The current system used to monitor staff compliance had been only recently implemented. 14. Clarification of the staff who had successfully completed all competency-based training was needed. 15. Establish benchmarks, a tracking system and schedule for compliance monitoring by the PNMPCs and effectiveness monitoring by OTs, PTs, and SLP. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP and the Dining Plan were addressed at an established frequency. 16. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 17. The consistency of monitoring and findings should be reviewed by the PNMT to establish effectiveness of existing supports for individuals referred to the team. 18. Consistency of monitoring and findings should be reported in the OT/PT/SLP annual assessment. 19. Review consistency of effectiveness monitoring as conducted by the OT/PTs/SLPs and the PNMT to ensure that the frequency is as recommended and that the guidelines are followed as to this process to address each of the necessary elements.

	20. Ensure that ISPAs are held to address changes in status and changes in supports and services, including termination. There should be a determination in every ISPA as to whether the PNMP, IRRF, and or IHCP need to be modified based on the identified issues and plans outlined. If no changes were necessary, this should be stated to demonstrate that this was considered. 21. Ensure use of trigger sheets was consistent with the facility guidelines. 22. Implement the established protocol and audit tool related to the process for assessment prior to tube placement. 23. Ensure completion of assessments, especially related to nutrition and oral motor, on an annual basis to contribute to the determination of the medical necessity of all individuals with enteral nutrition. 24. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF, and IHCP, as appropriate. 25. Establish clear support plans with clinical indicators for individuals with potential to return to oral intake and/or who would benefit from therapeutic intervention to address issues that may be barriers to return to oral intake.
	Summary of Monitor's Assessment: There was a fully appointed PNMT, though only the RN was a dedicated full-time member. The Director was developing a plan to review caseload assignments for Habilitation Therapists on the team in an attempt to free up time for greater active participation by these therapists. The facility should consider the addition of a diet technician to also permit greater participation by the dietitians. These clinicians must be supported to continue to expand their knowledge in order to provide appropriate assessment, analysis, and interventions to the many individuals who have significant health and medical complexities. This is accomplished by routine attendance at PNM-related continuing education courses for all members. There were significant concerns about the timeliness of the PNMT assessments and the timely response to referrals through the initiation of assessments or consultations. For example, there was a referral to the PNMT on 5/27/14 for assessment of Individual #90. This referral was not made in a timely manner by the IDT based on three falls in a 30 day period as required by the established criteria. In addition, the referral was not responded to for nearly a month and as of this onsite review, the individual had not been evaluated by the team. There are specific timeframes established and outlined in each of the monitoring reports and this was well outside those. The mealtime observations highlighted improvements in the dining areas. There were very few implementation errors, though logistics and environmental issues continue to need refinement. In each area, a Mealtime Coordinator was present, but in two cases, they did not recognize concerns with implementation prior to it being brought to their attention. They also needed to be prompted to address the problems identified. They seemed to understand their role to make the meal flow well, but not their responsibility to know the plans, monitor staff implementation, recognize errors, and provide coaching and intervention.

	In general, individuals were positioned correctly, but there were significant concerns for skin integrity that suggests that there is still much work to be done in this area across the 24-hour day. Positioning and re-positioning, attention to detail, correct equipment, and compliance with implementation are just some of the issues that require attention. Review of the medical necessity of enteral nutrition was initiated for individuals with existing tubes as well as a protocol for the review of each case prior to new tube placement. While it was noted that there were significantly fewer tubes placed, it could not be determined if this was a function of this new process. The point, however, is to not summarily dismiss the need for a tube for the sake of lowering the numbers, but to carefully analyze the risk/benefit of tube placement and make a determination on clearly identified clinical indicators. Following tube placement, there should be clear consideration for movement along the continuum of the least restrictive methods of intake. While not all individuals would be expected to return to oral intake, careful consideration of least restrictive supports is essential. The system recently developed for PNM monitoring that used the threshold database to identify individuals who experienced health or other risk concerns, but have not yet reached criteria for PNMT referral appeared to be a promising approach. The Habilitation Therapy Director analyzed the monitoring by the PNMPCs over at least a four week period to ensure that there were not ongoing issues related to the PNMP and its implementation. She is encouraged to also begin looking at this in a more preventative manner by initiating routine compliance monitoring and effectiveness monitoring by the therapy clinicians no less than quarterly to catch issues with the plans before they become threshold events. It was of concern that the monitoring conducted had not sufficiently addressed the occurrences of major skin wounds in a number of individuals. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 17 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. Sample O.3 consisted of individuals at LSSLC who received enteral nutrition, for whom APENs were submitted. Some of these individuals might also have been included in one of the other two samples.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed,	The facility used the state-approved PNM policy that addressed the broad scope of PNM issues outlined below, but also through a combination of other facility policies, guidelines, and procedural documents (e.g., At Risk Policy, ISP Policy, QA Policy, CAP Policy, the OT/PT Procedures, and the PNMT Referral Criteria and Guidelines) outlined a complete and comprehensive system of Physical Nutritional Management, and/or were in practice at the time of this review. These collectively included the following elements: • Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); • The annual review process of an individual's PNMP as part of the individual's ISP; • The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; • The roles and responsibilities of the PNMT; • 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; • Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); • The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; • Requirements for continuing education for PNMT members; • Referral process and entrance criteria for the PNMT; • Discharge criteria from the PNMT; • Assessment process; • Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; • The PNMT consultation process with the IDT; • Method for establishing triggers/thresholds; • Evaluation process for individuals who are enterally fed; • PNMT follow-up; • Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; • 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,	Noncompliance

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	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.	○ 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 relevant supervisor or clinician, and ○ Frequency of monitoring to be provided to all levels of risk. • A system of effectiveness monitoring; and • 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. Team members included the following, with start dates: • April Mettlen, RN (9/1/13) • Carrie Flowers, RD, LD (5/1/14) • Vickie McCarley, MA, CCC-SLP (1/1/13) • Nicholas Coco, OTR (4/1/14) • Cristen Nerren, PT, DPT (2/1/13) • Dalisa Smiley, PNMPC (5/1/13) This team had two new members since the previous review (RD and OT). Back-ups for each position were assigned, with the exception of the dietitian. <u>Consultation with Medical Providers and IDT Members</u> Each of the physicians, psychiatrists, pharmacists, physician assistant, and nurse were listed as the medical provider consultants to the team. Per the PNMT meeting minutes, a physician had attended one meeting pertaining to weight reviews from 1/23/14 through 7/17/14. There was no evidence that any other medical providers had participated in the PNMT meetings in the last six months. • For 0 of 4 individuals (0%) for whom evaluations had been completed in the last six months, evidence was provided of efforts by the PNMT to seek participation	

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		by medical staff review of assessment or and/or participation in the analysis of findings. While attendance at the meeting was an excellent method to gain the input of the medical staff, alternate methods to ensure their availability to the PNMT should be established. There was no representation at infection control or skin integrity meetings by the PNMT. The Pneumonia Committee was established on 3/19/14 and only four meetings had been held. The RN had attended two of these and the Habilitation Therapy Director had attended three. A subsequent meeting of this committee was held during the week of this review and attended by the monitoring team. The committee was in the process of establishing the role and process for review and the facility was encouraged to consider how the PNMT and this committee could be integrated to ensure collaboration without unnecessary duplication. One or more PNMT core members should attend each meeting. Daily medical provider meetings were held and the PNMT RN was present at 58/101 (57%) of these meetings. The Habilitation Therapies Director attended 19 of these 58 plus an additional 18 meetings, for total attendance at approximately 76 meetings (75%). Medical and IDT staff attended these meetings, serving as an excellent forum to ensure timely communication with other team members related to the individuals served by the PNMT and to identify others who would benefit from these services. For 10 of 25 PNMT meetings (40%) held from 1/23/14 to 7/17/14, there was evidence of participation by IDT members, including physicians, RNCMs, QIDPs, therapy clinicians, RDs, DSPs, and Unit Director. Though IDT members did not routinely attend PNMT meetings, the PNMT consistently reviewed their findings in an IDT/ISPA upon completion of the assessment and routinely attended IDT meetings related to individuals they reviewed or who were referred to the PNMT. The actual frequency of this was not evident in the documentation submitted. The PNMT's function was to provide support to the IDT, which included providing education and knowledge through recommendations, evaluation, and treatment. Action plans were the responsibility of the IDT in conjunction with the PNMT. The PNMT did not typically conduct initial meetings in order to work with the IDT in establishing the desired outcomes of the assessment process, though meetings upon completion were typically conducted. <u>Qualifications of PNMT Members</u> • The qualifications of the current PNMT members were as follows: 5 of 5 core team members (100%) were currently licensed to practice in the state of Texas.	

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		1 of 5 core PNMT members (20%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Collectively, the five team members had approximately 47 years of experience in their respective fields and, together, approximately 17 years with individuals with intellectual disabilities. The back-up team members had 49 years of experience in their respective fields and approximately 23 years with individuals with intellectual disabilities, for OT, PT, RD, and RN, as no RD back-up had been identified. <u>Continuing Education</u> 1 of 5 PNMT core team members (20%) had completed continuing education directly related to physical and nutritional supports and transferable to the population served within the past six months. The SLP and PT back-up team members were also listed with related continuing education in the last six months. One relevant course was attended by the PT core team member only: • Combining Evidence-Based Manual Therapy and Kinesiology Taping (six contact hours) Collectively, this team had limited experience in their individual fields, as well as limited experience working with individuals with complex PNM needs and developmental disabilities. 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> • Since the last review, the PNMT met at least once for 25 of 26 weeks (96%) from 1/23/14 to 7/17/14 (meeting minutes submitted for that period). The team met additional times to review findings from assessments with the IDTs for individuals served by the PNMT, though these meetings were not clearly documented. • Based on review of the minutes, attendance at the weekly meetings by core PNMT members and/or back-ups for the meetings conducted during this period was: o RN: 24/25 (96%) by core member, 0/25 (0%) by back-up, 96% overall. o PT: 25/25 (100%) by core member, 0/25 (0%) by back-up, 100% overall. o OT: 24/25 (96%) by core member, 1/25 (4%) for back-up, 100% overall. o SLP: 22/25 (88%) by core member, 3/25 (12%) for back-up, 100% overall o RD: 20/25 (80%) by core member, 3/25 (12%) for back-up, 92% overall o PNMPC: 24/25 (96%)	

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		Absences for core team members without a backup were noted only on 4/10/14 for the RN and 4/24/14 and 5/8/14 for the RD. Attendance was well above or within the criterion of 80% for all core team members and above the criterion of 90% overall for all disciplines. This was an improvement from the previous review. • Since 9/5/13, all PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (d) PNMT actions, (e) follow-up, and (e) outcomes/progress toward established goals and exit criteria were clearly outlined on a consistent basis. The meeting minutes were maintained, but did not consistently include each of the following elements: • Current weight • EDWR • Level of PNMT Involvement • Reason for referral • Discussion • Measurable Outcomes • Exit Criteria • Action Steps, Person(s) Responsible, and Due Date The team member attendance next review date appeared to be consistently noted. The current format did not permit ready review of action steps, responsible person, and dates due or completed. The facility may want to review documentation from other facilities to see other formats that may address these issues. • The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns, though it was not routinely accessed by the team for systems issues as indicated. This was integrated into the policies and procedures in place and evidenced in the monthly QA reports. There was a system of corrective action plans (CAPs) when system issues were identified. They addressed the following: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT are collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the 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	

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		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 required 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 was to be developed with input from the IDT, home staff, medical and nursing staff, and the PNMT. These aspects, though outlined in O.1 of the Settlement Agreement, are actually reviewed in O.3 below. The facility self-rated this provision not in substantial compliance 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 adequate participation by medical providers in the process of PNMT assessment and review. This may involve review of assessments, attendance at meetings, attendance at IDT meetings in which the provider also attends, improved representation at facility meetings in which interaction would be promoted. These methods should be easily documented and tracked. 2. The PNMT should consider initial meetings with the IDT for individuals who were to be assessed by the team, in order to plan the assessment process and establish outcomes and exit criteria. The PNMT should continue meeting with the IDT to introduce the assessment findings and develop an intervention plan. Further, at the time of discharge, the PNMT should also meet with the IDT to ensure that outstanding actions were attended to and that all supports and interventions were clearly integrated into the ISP and IHCP. The teams should determine what, if any, level of continued follow-up was indicated. 3. Consider revision of the current meeting minute format to ensure that action steps, person(s) responsible, due dates, as well as, key clinician indicators, measurable outcomes and exit criteria were tracked at the time of each review to determine the individual's status.	
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	<u>Identification of PNM risk</u> The majority of individuals at LSSLC (87% per document request) 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	Noncompliance

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	positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	reported to be provided a current PNMP. Based on lists of individuals with identified PNM concerns, there were individuals who (a) required physical assistance for positioning associated with swallowing: 114 individuals, (b) were dependent on others to eat: 62 individuals, (c) had difficulty swallowing: 228 individuals, and/or (d) were considered to be at medium or high risk of choking (approximately 218 individuals) or aspiration (approximately 155 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), 19 individuals were not listed with a PNMP. Some of these likely had at least a Dining Plan to address these concerns, but this was not identified in the list of PNMPs (Individual #297, Individual #500, Individual #394, Individual #300, Individual #261, Individual #477, Individual #330, Individual #479, Individual #249, Individual #556, Individual #453, Individual #318, Individual #97, Individual #66, Individual #344, Individual #524, Individual #126, Individual #505, and Individual #240). There was one choking event requiring abdominal thrusts (Heimlich) since the previous review (Individual #241 5/4/14). The SLP conducted a chair-side assessment the following day and modified the Dining Plan with temporary changes pending full evaluation and monitoring. There was no evidence of these temporary changes in a plan, but the IPN indicated these as recommendations. A notation on 5/21/14 indicated that additional changes were to made in red on the PNMP and dining card until the permanent changes were made. It was presumed that this was also done the first time, though this was not clearly documented. It was noted that the Dining Plan was changed on 5/7/14, three days after the incident and again on 5/23/14 after the follow-up assessment. There was no evidence of an ISPA held until 5/6/14, referred to as an update. Though there were IDT member signatures, it was not clear if this was merely written by the clinician rather than an actual IDT meeting. There was another follow-up ISPA held on 5/21/14. Again, it was not clear that this was an actual IDT meeting; the ISPA was unsigned. This incident warranted a full IDT meeting with documentation by the QIDP in an ISPA. <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 had been unable 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. Levels of PNMT action included discussion, investigation, and/or action. The criteria for referral included the following: • Choking incidents, per IMRT recommendation • One confirmed episode of aspiration pneumonia in one year	

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		• Results of PNMT Nurse Post-Hospitalization Review for individuals diagnosed with any of the following:
		  ○ Aspiration Pneumonia
		  ○ GI Issues
		  ○ Fractures
		  ○ Skin Integrity
		  ○ Seizures
		• New enteral feeding, if not returned to oral eating 90 days post tube placement and without clinician indication to remain NPO
		• Unresolved vomiting (more than three episodes in 30 days not related to viral infection)
		• Unresolved falls (more than three episodes in 30 days)
		• Significant unplanned/verified weight loss or gain, with notification from dietitian. Significant defined as:
		  ○ More than five pounds in one month
		  ○ Three or more pounds per month for three consecutive months or 7.5% of body weight for three consecutive months
		  ○ 10% of body weight in six months
		• Any Stage III or IV decubitus, or any Stage II with delayed healing
		• Fracture of a long bone, spine, or hip, per IMRT recommendation
		
		Routine PNMT tracking for PNM-related concerns was not noted for aspiration pneumonia, emesis, decubitus, falls, fractures, choking incidents, individuals monitored for weight loss, and hospital visits. Episode tracking would permit the team to determine when and if an individual met any of the above criteria, in case this was not recognized by the IDT for referral. The facility-wide threshold system was in place, but it was not clear how that system interfaced with the PNMT relative to the criteria established for referral by the IDT in a timely manner.
		
		There were eight individuals listed on the current active caseload for the PNMT (Individual #101, Individual #368, Individual #441, Individual #47, Individual #560, Individual #240, Individual #203, and Individual #33), though Individual #101 was not listed as referred. Discharge criteria were established via the assessment and at the time they were met, transition from the PNMT to the IDT was planned.
		
		Lists related to the incidence of PNM-related concerns were reviewed to determine if individuals who met the criteria above were appropriately referred to the PNMT. Related to falls, there were at least 15 individuals who had met criteria for three or more falls in three months. Only three had been referred to the PNMT (Individual #33, Individual #368, and Individual #90). A review by the PNMT was documented on 6/5/14 of the top	

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		10 individuals with falls from 3/1/14 to 5/31/14. This was an unsigned document, and though there were recommendations, it was not clear how or if this was presented to the IDTs who served these individuals. There was follow-up documented for Individual #189 and Individual #547 related to falls on 6/26/14, only to report the findings of monitoring that had been conducted. It was noted that only two had actually been evaluated (Individual #33, Individual #368). On 5/27/14, an Action Referral Notice was sent to the PNMT by the QIDP who reported that Individual #90 had experienced over 13 falls in a five month period. The IDT met and wanted to initiate the referral at that time. Upon review, Individual #90 had met criteria for referral on or before 9/4/13, when she had experienced at least nine falls in three months, though this was noted to be a concern as far back as 2012. The IDT received a response to this request three weeks later, indicating that the PNMT would complete an assessment. At the time of this onsite review (six weeks after the initial referral), the assessment had not been initiated. Over 10 months after Individual #90 had met criteria for referral, she had yet to be evaluated by the team. Four individuals were identified as meeting criteria for referral related to skin integrity (Individual #467, Individual #316, Individual #46, Individual #586, and Individual #556). None had been referred to the PNMT related to this, nor had the team initiated a self-referral. Some of these were recently staged as III and IV. Individual #241 was not referred related to the choking event described above. Individual #545 was not referred related to a femoral fracture on 2/25/14. Individual #422, Individual #238, Individual #185, Individual #447, and Individual #67 were not referred relative to new tube placement in the last six months. Six individuals were listed with unplanned weight loss of 10% or more in a six month period (Individual #357, Individual #203, Individual #22, Individual #547, Individual #187, and Individual #163). Only two were referred: Individual #203 and Individual #357. It was noted that there were at least seven individuals listed with aspiration pneumonia, yet only three of those had been referred (Individual #203, Individual #108, and Individual #174). Per the documentation submitted, five individuals in Sample O.1 had been reviewed by the PNMT in the last six months (Individual #368, Individual #586, Individual #108, Individual #203, Individual #174, and Individual #294), though only Individual #203 had been evaluated by the team during that time. He and Individual #368 were listed as on the active caseload for the team. All but Individual #586 were listed as referred to the PNMT in the last 12 months. Only in the case of Individual #203 was there evidence of an ISPA related to the reason for referral to the PNMT. There were five individuals listed who had received enteral tube placements since the previous review (Individual #422, Individual #238, Individual #185, Individual #447, or Individual #67). • 0 of 5 (0%) of individuals who received a feeding tube since the last review had	

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		been referred to the PNMT prior to the placement of the tube. • 0 of 5 (0%) individuals who received a feeding tube placement since the last review had been referred to the PNMT after the tube placement. There was no evidence of review by the PNMT. None of these appeared planned, but it was not clear if they were placed on an emergency basis, precluding review by the team. <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 completed in the last six months included the following: Individual #33 (3/18/14), Individual #101 (3/27/14), Individual #203 (2/20/14), and Individual #240 (3/5/14). Only Individual #240 was referred by his IDT; the others were stated to be self-referred. It was noted in the meeting minutes for Individual #203, however, that the team had received a referral from the IDT on 1/23/14, though the report indicated that he had been self-referred on 1/15/14. There was also evidence that an initial referral was indicated in November 2013. • 2 of 4 PNMT assessments (50%) were initiated at a minimum within five working days of the referral, per the dates in the assessment, meeting minutes, and IPN documentation. It could not be determined when the assessments for Individual #33 and Individual #203 were initiated. • 1 of 4 PNMT assessments (25%) was completed in 30 days or less of the date of referral on the assessment, per the assessment dates (most of the signatures were not dated). An additional PNMT assessment completed in the last six months was noted in the individual record for Individual #174. He was referred to the PNMT on 3/6/14 and it appeared that they initiated the assessment at that time. There was no documentation of actions taken on his behalf by any PNMT member from that time until 5/29/14 when a HOBE assessment was conducted. There was no documentation of review by the team in the meeting minutes until three months later on 6/5/14. The assessment was not completed until 6/26/14 and the PNMT did not meet with the IDT until 7/10/14. This was of significant concern to the monitoring team. He had been referred related to recurrent pneumonia described as six episodes from April 2013 through May 2014. Clearly, the PNMT did not understand the urgency of actions required on their part to complete an assessment and implement interventions to address the physical and nutritional needs of the individuals referred to them. Based on review of these assessments, the following elements were addressed (individual #s in parentheses refer to those assessments that did not contain that element):	

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		• Date of referral by the IDT or self-referral and the referral source (4 of 4, 100%). • Date the assessment was initiated (2 of 4, 50%) (Individual #203 and Individual #33). • Evidence of review and analysis of the individual's medical history (4 of 4, 100%). • Identification of the individual's current risk rating(s), including the current rationale (1 of 4, 100%). (Individual #33, was related to falls only). • Recommended risk ratings based on the PNMT's assessment and analysis of relevant data. (3 of 4, 60%) (Individual #240). This was consistent with the previous review. It may be implied that the PNMT agreed with the most current risk assessment, but this was not always clearly stated. • Discussion of the impact of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition (0 of 4, 0%). • Assessment of current physical status (0 of 4, 0%). • Information about the individual's current respiratory status based on a physical assessment (0 of 4, 0%). • Assessment of musculoskeletal status (0 of 4, 0%). • Evaluation of skin integrity (0 of 4, 0%). • Evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning (0 of 4, 0%). • Positioning that may impact PNM status, including during bathing, medication administration, and oral hygiene based on observations of these activities (0 of 4, 0%). • Evaluation of motor skills (0 of 4, 0%), though limited. • List of medications with potential side effects listed with individual allergies. This generally addressed drug/drug or drug/nutrient interactions and/or actual side effects (4 of 4, 0%). The purpose of the each medication was not documented. • Evidence of review/analysis of medication history over the last year and current medications, such as dosages, and side effects (0 of 4, 0%). • Evidence of review/analysis of lab work (0 of 4, 0%) • Identified residual thresholds, if enterally nourished (0 of 2, 0%). • Tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation (0 of 4, 0%). • Evidence of observation of the individual's supports at their home and/or day/work programs (0 of 4, 0%). • Nutritional assessment was adequate (0 of 4, 0%). Evaluation of nutritional status and needs was very limited and inadequate or non-existent. • Evaluation of current assistive equipment (0 of 4, 0%). • Evidence that the PNMT conducted hands-on assessment (0 of 4, 0%).	

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		• Identified the potential causes of the individual's physical and nutritional management problems (3 of 4, 0%). (Individual #101) • Identified physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations (0 of 4, 0%). This was often not addressed in the analysis, but rather recommendations were listed without a clear justification in the analysis section. A number of recommendations pertained to assessments that should have been completed for the PNMT assessment. For example, in the case of Individual #33, the PT was to evaluate for sitting and ambulation to ensure that the current process was appropriate for her. It was not acceptable that this had not been done, when the reason for her referral was related to falls and this should be a core finding in any assessment. Her assessment took nearly three months to complete and key findings were still outstanding. • Recommendations for measurable skill acquisition programs, as appropriate (0 of 4, 0%). • Evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP) (0 of 4, 0%). • Recommendations for monitoring, tracking or follow-up by the PNMT (4 of 4, 0%). There was no delineation of monitoring responsibilities to be completed by the PNMT in the assessment, and many did not specify what specifically should be monitored or how often. For example, it was recommended that the PNMPC continue to monitor Individual #33 on her home per schedule for compliance. What they were to monitor or how often that should occur based on the PNMT findings was not outlined. • Discussion as to whether existing supports were effective or appropriate (5 of 5, 100%). Monitoring data and effectiveness data previously gathered by the IDT were not consistently reported. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status (0 of 4, 0%) This is not the same as criteria for discharge. In the case of Individual #101, one recommendation was that the RN case manager was to monitor her weekly weights. There was no mention of her actual weight until the last page of the report when a discharge criteria related to weight gain was identified. Weight, height BMI and other nutritional health indicators are clear baseline clinical data that should be reported, analyzed and addressed in the analysis of finding to build the rationale for recommendations and interventions. Most individuals had no PNMT nutritional assessment to address these significant concerns. • Measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT (0 of 4, 0%). The outcomes listed appeared to be limited to PNMT discharge criteria.	

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		• Signatures of all core team members (or alternate) with dates (0 of 5, 0%). All team members had signed the reports, but only one clinician or none dated those signatures. These assessments were extremely weak and did not reflect any real assessment by the full PNMT, but rather record review, largely by the RN on the team. In many cases, the recommendations appeared to relate to interventions and supports that were already in place. The purpose of this team was to provide physical and nutritional assessment by an interdisciplinary team to determine the root cause of chronic and/or acute health concerns and collaborate with the IDT to develop a plan to address those issues. There was no evidence of a physical assessment or nutritional assessment in any case. The discussions observed by the monitoring team were good, but the collaboration across team members noted in the meeting was in no way reflected in the assessments reviewed. The entire assessment format was reviewed with the RN to guide the team in ensuring that improvements were implemented as soon as possible. Other specific concerns noted are below: • 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. These should be integrated into the IHCPs and IRRFs. 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. These will not likely be the same objectives for re-assessment or discharge from the PNMT. • It is recommended that the team establish guiding questions to ensure that the content for the assessment and analysis is consistent and comprehensive. There were a number of recommendations that did not have a clearly stated rationale in the analysis. The assessment should present and analyze pertinent objective data, identify the basic underlying causes of the issues that resulted in referral, and clearly establish the rationale for recommendations, actions, and supports required. These should be clearly linked to an aspect of the analysis. • The PNMT should establish measurable outcomes as indicators of improved health as they provide supports, criteria for discharge, criteria for review, and criteria for re-referral. As stated above, the clinical indicators established for IDT monitoring may not be the same as for re-referral or discharge. The team should consider whether it is acceptable, for example, that an individual be re-referred for a repeat aspiration pneumonia, rather than perhaps sooner when the clinical indicators established indicate that there was a change in status. Antecedents should be identified to alert care providers to take specific actions. • All clinician assessments were weak or non-existent. It is critical that this be	

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		adequately addressed. None of the assessments provided adequate detail for implementation by the IDT and certainly not as a document record of the outcomes and recommendations related to PNMT supports and services to this individual. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> Due to the weak assessments, this was not assessed at this time. It was reported that the PNMT generally met with the IDTs to review their findings and this was noted in the meeting minutes for three of the four individuals assessed in the last six months. ISPAs were not consistently noted for meetings held between the PNMT and IDT, but rather a notation in the meeting minutes that were filed in the PNM section of the individual record. This is not integration into the ISP, but rather a system, separate and apart from the IDT and the ISP process. <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 with timely implementation. This could not be adequately determined by the documentation. In many cases, an action was documented in the meeting minutes, but with no due date or follow-up discussion. The PNMT may want to consider revising the format of their minutes to be in an action plan format to ensure that they follow-up on each recommendation and action and record the timeliness of completion and the outcomes or findings. They may also want to develop a recommendation log in order to track its own timeliness other PNMT s have done. The following metrics were not addressed • For --% of individuals (NA), implementation of individual action plans was within 14 days of development of the plan or sooner as needed for health or safety. • For --% individuals (NA), action plan steps had been generally completed within established timeframes. This could not be determined based on the IHCPs submitted because the completion dates were not documented. The intervals of PNMT review was clearly stated in all but one case and these generally appeared to occur on a timely basis, though this was difficult to track. IPNs were not consistently entered by the PNMT, though primarily by the RN. These generally reflected actions taken, outcomes, or plans. The meeting minutes were filed in the PNM section of the individual record as a rolling record. While this made it easy to see the PNMT documentation because it was not a part of the continuous record in the IPNs, it was likely that most if not all of that information was not used by the IDT.	

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		Individuals Discharged from the PNMT Discharge was noted for the following individuals: Individual #336, Individual #542, Individual #306, and Individual #560. • A discharge summary provided objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP for 3 of 4 individuals (75%). This was contained in the sequence of PNMT meeting minute notes rather than a discharge summary report or IPN. There should be at least a progress note written to address the course for intervention, outcomes, progress with established criteria, and plans or recommendations. • There was evidence of ISPA documentation for discharge of 4 of 4 (100%) individuals, though these did not consistently include specific clinical indicators to track health status and criteria for referral back to the PNMT. These often were merely the threshold (i.e., referral criteria) that put them on the PNMT in the first place. It was not acceptable that an individual could regress again to that same point before the PNMT was again involved. As has been noticed in the past, it appeared that the ISPA was merely documentation of the change in status, rather than a meeting with the IDT to discuss discharge plans. For example, for Individual #560 and Individual #306, it was documented that an ISPA would be "sent" to the IDT for notification. In the case of Individual #542, who was referred due to falls, it was considered "acceptable" for him to fall again three times within 30 days of the PNMT discharge before re-assessment by the team. 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 urgency to complete PNMT assessments. Even so, some interventions may need to be implemented immediately, before the written report is finalized. It is critical that the assessments be completed in a timely manner. At this time, the LSSLC PNMT did not appear to understand this responsibility and it was of concern that the PNMT did not take action sooner, based on documentation review, related to individuals who experienced PNM-related incidents to solicit or initiate referrals and to initiate and complete adequate and comprehensive assessments in timely manner. The facility self-rated this provision in non-compliance, 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 referrals are initiated by the IDT and/or PNMT in timely manner so that the assessments are conducted in a timely manner that reflects the urgency of the identified PNM needs. 2. Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs.	

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		3. Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly, succinctly, and in a timely manner. 4. Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in an ISPA meeting. 5. Consider a recommendation log to readily track completion of action steps.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>Identification of Individuals Requiring a PNMP</u> As described above, approximately 94% of individuals with identified PNM needs were provided a PNMP at LSSLC. The self-assessment indicated that 100% were provided plans, but that could not be verified based on the documentation submitted. The Settlement Agreement (in O.1, 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. Review of the PNMP and Dining Plans is required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT/speech and the PNMT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the PNMT, OT, PT, and/or SLP clinicians. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. For individuals in Sample O.1, ISP attendance and pre-ISP documentation related to required attendance were reviewed. The most current ISPs were submitted for 17 of 17 individuals included in sample O.1. Pre-ISP required attendance sheets were only submitted for three individuals. • For 0 of 17 individuals (0%), the appropriate disciplines were present at the ISP meeting to approve and integrate the PNMP into the ISP. Though there were one or more Habilitation Therapies representatives at 16 of 17 meetings, neither of the SLPs who focused on swallowing was present at any of these meetings and a communication SLP was present at only two. A dietitian attended only 1of the 17 ISPs. This professional is a key team member, particularly as it related to PNM concerns. Though psychiatry was represented at seven meetings, a PCP was not present at any meeting. The RN was the only provider present at each of the 17 meetings. DSPs were present at 16 of 17 meetings. • For 2 of 3 individuals for whom pre-ISP required attendance sheets were submitted (67%), the designated team members were present for the ISP meeting per the sign-in sheet (the exception was Individual #376 where the Behavioral Health Specialist was not present as designated).	Noncompliance

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		Regarding PNMP review: • 16 of 17 PNMPs (94%) indicated some level of review by the individual's IDT in the annual ISP meeting. The reviews documented in the ISPs varied significantly in specificity and thoroughness, and not all clearly identified what changes were required. Some did not specify that the IDT had approved proposed changes. None addressed the efficacy of the plan overall, though some aspects were addressed in the risk discussion. None specified the frequency of monitoring needed. • The following metric was not adequately assessed as 12 months of PNMPs and Dining Plans were not submitted as requested: o For % individuals in Sample O.1 for whom the IDT identified changes needed to be made to the PNMP in the interim of the annual ISP, revisions based on the IDT discussion were documented in an ISPA. These did/did not include a clear rationale, plan, or timeline for implementation with evidence of completion in a timely manner. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 17 of 17 individuals (100%) were current within the last 12 months. This was consistent with the previous review, though PNMPs for Individual #467, Individual #546, Individual #545, Individual #368, and Individual #90 were incomplete as submitted (at least one page and/or picture pages were missing). • PNMPs for 14 of 17 individuals (82%) included a list of PNM risk levels and individual triggers. This was a decrease from 100% in the previous review. • In 16 of 17 PNMPs (94%), there were large and clear photographs with instructions. This was a decrease from 100% in the previous review. • 14 of 17 PNMPs (82%) identified the assistive equipment required by the individual with rationale and purpose. This was a decrease from 100% in the previous review. • In 9 of 11 PNMPs (82%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair. This was consistent with the previous review. • In 12 of 17 PNMPs (76%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was a decrease from 100% in the previous review. • In 15 of 17 PNMPs (88%), the type of transfer was clearly described, or the individual was described as independent. This was an improvement from 77% in the previous review. • In 14 of 17 PNMPs (82%), bathing instructions were provided. This was an	

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		improvement from 69% in the previous review. • In 14 of 17 (82%) PNMPs, toileting-related instructions were provided, including check and change. This was an improvement from 13% in the previous review. • In 15 of 17 (88%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning, or individual was described as independent. This was an improvement from 23% in the previous review. • In 15 of 17 PNMPs/dining plans (88%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was a decrease from 100% in the previous review. • 0 of 17 individuals' (0%) Dining Plans were current within the last 12 months. This was consistent with the previous review. None were submitted. • 5 of 17 individuals had feeding tubes with no oral intake. 5 of 5 PNMPs plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. 0 of 5 Dining Plans were submitted. This was consistent with the previous review. • In 0 of 17 dining plans (0%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. None were submitted. This was consistent with the previous review. • In 10 of 12 PNMPs (83%) for individuals who ate orally, diet orders for food texture were included. The exceptions were Individual #241 and Individual #368. No Dining Plans were submitted. This was a decrease from 100% from the previous review. • In 8 of 12 PNMPs for individuals who received liquids orally (67%), the liquid consistency was clearly identified. In cases that regular liquids were approved, this should be stated, otherwise it is unclear if this was omitted from the plan or was intended to suggest that the individual had no special liquid consistency. No Dining Plans were submitted. This was consistent with the previous review. • In 11 of 12 PNMPs for individuals who ate orally (92%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular dining utensils. This was a decrease from 100% in the previous review. In 14 of 17 PNMPs (82%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. This was a decrease from 92% in the previous review. • In 14 of 17 PNMPs (82%), oral hygiene instructions were included, including general positioning and brushing instructions. This was an improvement from 13% in the previous review. • 14 of 17 PNMPs (82%) included information related to communication (how individual communicated. A number of these were excellent with very clear	

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		descriptions of how the individual used their AAC. Most still provided very little as to how staff should communicate with the individual, however. This was an improvement from 31% in the previous review. The PNMPs continued to be good, with continued comprehensive content in most areas. Most of the omissions described above were most likely attributed to the missing pages in the copies submitted, with a few exceptions. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> The following metrics could not be assessed as 12 months of PNMPs and Dining Plans were not submitted as requested: • For % of individuals with a change in status, ISPA meeting documentation noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status other than PNMT assessment findings. • For individuals for whom the PNMP was revised, there was supporting documentation that % of the revised PNMPs had been implemented. The changes were or were not made that day or within 48 hours. Other non-critical changes were or were not made in less than 30 days. The monitoring team concurred that the facility was not in substantial compliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility should review the system of the determination of who should attend the ISP during the pre-ISP. This was not consistently documented and it was not clear that the IDTs considered the need to review the PNMP and other aspects of the individual's annual plans in these determinations. Attendance should then be consistent with these determinations. 2. Ensure better communication across Habilitation Therapy professionals for improved representation at the ISPs/ISPAs. 3. All designated changes to the PNMP identified in the ISP/ISPA must be made and implemented within 24 to 48 hours for critical changes and no more than 30 days for changes that were non-critical to health and safety. Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPs and ISPAs. It was common practice that the clinicians wrote an ISPA to inform the IDT as to needed changes in the plans and interventions, without an actual meeting held for discussion. While this may be an acceptable way to handle some changes, guidelines should be clearly established as to when a meeting would be required.	

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O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were generally readily available in the dining areas and PNMPs were included in the individual notebook. General practice guidelines (foundational training) were taught in NEO, in individual-specific training by the therapists, PNMPCs, and residential staff, and other training as specified by the Red Dot system, though this was infrequent. Based on observations conducted by the monitoring team: • 90% of dining plans were implemented as written for at least 50 individuals observed. • 93% of PNMPs for approximately 70 individuals related to positioning and mobility were implemented as written, or alignment and support were consistent with generally accepted standards. Based on additional observations: • 80% of 5 transfer plans/repositioning were implemented appropriately or 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. • (NA) individuals' oral hygiene plans were implemented appropriately or consistent with the PNMP. No oral hygiene was observed during this review, so this metric was not rated. • In one observation of medication administration for individual by the monitoring team, the SSLC nurse followed procedures in the PNMP. Additional observations (12) were reported in section M and only one of those was within generally accepted standards, including following the PNMP. Refer to section M for more detail. The facility implemented Mealtime Coordinator (MTC) training consistent with the statewide plan. A Mealtime Coordinator was seen in each of the homes, though the roles were not clearly established in some. In two cases, the MTC had not identified issues related to implementation prior to the monitoring team bringing these to their attention. Though they acknowledged the point, they had to be prompted to take action to correct the problems. Though they appeared to understand their role to make the meal flow smoothly, they did not understand their responsibility to understand each of the Dining Plans, to monitor staff implementation, and to provide coaching and intervention when required. Standardization of this process is essential to ensure adequate competency of these key staff. All unit directors need to be intimately involved in implementation and oversight of the program.	Noncompliance

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		7 of 10 (70%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan. These questions pertained to rationale for assistive equipment, areas of risk and triggers, rationale for food textures and liquid consistencies, transfers, and positioning. 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 monitoring team concurred that the facility was not in substantial compliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility should ensure that the Mealtime Coordinator position is adequately implemented across all homes for all meals. 2. Continue drills related to staff understanding risks and the rationale for PNM strategies contained in the PNMPs and Dining plans. 3. The current system used to monitor staff compliance had been only recently 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.	<u>NEO Orientation</u> LSSLC had a system of comprehensive competency-based training regarding PNM services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of PNMPs. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time was across two full days to address the PNMP, lifting and transfers, and dining plans and eating skills. The Lifting and Transfers portion of the curriculum was now taught by therapy clinicians as the primary instructor rather than the therapy technician as before. 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. The	Substantial Compliance

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		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. PNMP, Lifting, Positioning, Optimal Eating Skills and Mealtime Management portions of the curriculum were reviewed and updated since the previous review. 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, and PNMPCs. It did not appear that a formal system to ensure continued competency was in place, however, the therapy clinicians were reported to routinely sit in on training to address differences in presentation style or content. • 110 of 111 (99%) of new employees successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs from January 2013 through May 2014. Two staff had to repeat the check-off for lifting/positioning and passed on that second attempt. One other staff was retested a second time for lifting/positioning and was terminated when unable to pass the check-off at that time per the self-assessment. Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. The data presented in the self-assessment was not consistent. There were two elements that addressed auditing to ensure that existing employees completed annual refresher training pertaining to PNM. The third element reported the following: • 364/364 (100%) of staff required to take the Annual Refresher class related to Lifting/Positioning successfully passed the competency check-offs, though some had to retake the class, but successfully passed the second time. • 167/167 (100%) of staff required to take the Annual Refresher class related to Optimal Eating Skills successfully passed the competency check-offs, though some	

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		had to retake the class, but successfully passed the second time. The 10th element reported the following: • 351/497 (71%) of existing staff who were required to take the Lifting/Positioning portion of annual refresher training, completed the training. This was not consistent with the other data reported. • 90/497 (18%) of existing staff who were required to take the Preventing Aspiration portion of annual refresher training, completed the training. This was not consistent with the other data reported. • There was no system to establish and maintain competency for staff who provided this training, though audits were routinely conducted. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO/refresher training curriculum. This type of training required competency check-offs in order that staff could implement that element. This was referred to as the Red Dot system. A red dot on the plan indicated that only staff who had specifically been competency-trained to complete that element of the PNMP were permitted to implement it. Further changes to the plans were trained as indicated, though some of those did not require specific competencies to be repeated because it was primarily an information exchange. These were generally conducted by the PNMPs, therapy assistants, and/or therapy clinicians. The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. • Per the system in place, 100% of the staff assigned to individuals were trained related to individualized PNMP strategies prior to the provision of services. This did not yet apply specifically to pulled staff beyond the foundation skills taught in NEO, however. The facility was in the process of developing a system to address this. • Per the system, 100% of the staff assigned to individuals had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. • The facility had a process to 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 substantial compliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months:	

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		1. Clarification of the staff who had successfully completed all competency-based training was needed. 2. Develop a clear system to ensure that staff responsible for training others were competent to do so (NEO and Annual Refresher training)	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> <u>Monitoring System</u> The facility had recently implemented a system for the adequate monitoring of PNMPs conducted by the PNMPCs. This included staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment. The standardized system for compliance monitoring of the PNMPs and Dining Plans consisted of a determination of frequency based on related to risk levels and threshold criteria and appeared to be very good. This was generally conducted by the PNMPCs as directed by the Habilitation Therapies Director. • The tools included adequate indicators to determine whether staff demonstrated competency to safely and appropriately implement the PNMP. • There were sufficient instructional guidelines for those using the forms to monitor. • All monitors (PNMPCs) and therapy clinicians were competent to monitor the PNMP elements based on the training submitted. • The Director was encouraged to also ensure that routine monitoring occurred for all individuals with PNM-related supports and services rather than only those who were presenting with problems (at or near thresholds for risk areas). This ensures a proactive approach rather than merely a reactionary one in order to catch problems with competency, compliance and effectiveness before a problem occurred. The following could not be determined as compliance monitoring sheets for individuals in Sample O.1 were not submitted as requested, though it appeared that at least nine had been monitored at least one time since 3/3/14, per the list provided. • PNMP Monitoring was not conducted at the established frequency described in the assessments for --% individuals. For --% of individuals, monitoring occurred across all three shifts. • For --% individuals, the PNM monitoring process adequately balanced all areas that were likely to provoke swallowing difficulties, or increase other PNM risk, including: o Meals o Bed positioning o Wheelchair positioning o Medication administration	Noncompliance

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		○ Oral care ○ Bathing ○ Transfers • Mealtime Monitoring was conducted at the established frequency for --% of individuals. • By report, effectiveness monitoring to be conducted by the therapy clinicians had not yet been implemented. This element was self-rated to not be in substantial compliance and the monitoring team concurred. While there was a recently established system of compliance monitoring, compliance with the recommended frequency could not be assessed as no completed forms were submitted. 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 benchmarks, a tracking system and schedule for compliance monitoring by the PNMPCs and effectiveness monitoring by OTs, PTs, and SLP. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP and the Dining Plan were addressed at an established frequency. 2. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 3. The consistency of monitoring and findings should be reviewed by the PNMT to establish effectiveness of existing supports for individuals referred to the team. 4. Consistency of monitoring and findings should be reported in the OT/PT/SLP annual assessment.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Monitoring by the IDT and/or PNMT to Assess individual Progress and Plan Effectiveness</u> There was also a system established for effectiveness monitoring by the therapists, though this was not clear based on the documentation submitted. The frequency was not reported as a recommendation in the annual assessments or the PNMT evaluations. Effectiveness monitoring guidelines should indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale IHCPs did not consistently contain indicators identified to assess the individual's PNM status. Based on the sample of individuals selected for O.1, evidence of effectiveness monitoring for each was requested for the last six months. None was submitted as it was reported that this was not yet implemented. The PNMT consistently made	Noncompliance

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		recommendations for the IDT to conduct monitoring, but the role they played in that process was not always clearly stated. The monitoring team concurred that the facility was not in compliance with this provision. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Review consistency of effectiveness monitoring as conducted by the OT/PTs/SLPs and the PNMT to ensure that the frequency is as recommended and that the guidelines are followed as to this process to address each of the necessary elements. 2. Ensure that ISPAs are held to address changes in status and changes in supports and services, including termination. There should be a determination in every ISPA as to whether the PNMP, IRRF, and or IHCP need to be modified based on the identified issues and plans outlined. If no changes were necessary, this should be stated to demonstrate that this was considered. 3. Ensure use of trigger sheets was consistent with the facility guidelines.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Evaluation of Individuals who Received Enteral Nutrition</u> • The facility maintained and updated a list of individuals who were enterally fed. There was a list of individuals that identified 83 individuals who received enteral nutrition, or 25% of the total census. This was very high and the number of tube placements over the last two years (17) was also atypically high. All were identified as gastrostomy tubes. Thirty-five received intermittent feedings, 26 received continuous feedings, 12 received bolus feedings, and 10 had the tube used for medications, flushes, and/or meal refusals. Sixty-five were identified as NPO and 18 received pleasure feedings. At least 24 of these individuals (29%) had experienced one or more episodes of pneumonia from 11/1/13 through 5/30/14. Two of these had three occurrences (Individual #174 and Individual #357). At least one episode for Individual #174 was classified as aspiration pneumonia. Eight others had at least two occurrences in the same time period and at least one was classified as aspiration pneumonia for Individual #203 and Individual #108. Fourteen others had at least one occurrence with aspiration pneumonia noted for Individual #185 and Individual #586. A sample of 10 APENs completed since the previous review was requested. Each was submitted as complete. Three of these individuals were included in sample O.1 and the IRRF was submitted for each for review. • At least 4 of 4 individuals (100%) who received enteral nutrition (Sample O.3) were evaluated at a minimum annually based on the APENs submitted. • 0 of 4 individuals with APENs (0%) had an appropriate evaluation to determine	Noncompliance

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		the medical necessity of the tube since the previous review. Most did not appear to present a determination if the feeding schedule was the least restrictive or if there were potential modifications needed in preparation of transition to oral intake. There was insufficient assessment by the dietitian, though the diet order and rate were generally reported. Oral motor assessments were not noted. All other APENs were completed for individuals with pneumonia, but who ate orally, so this metric did not apply. • For 0 of 1 individuals (NA), for whom the IRRF was submitted, there was evidence of adequate discussion by the team related to the medical necessity of the team (Individual #586). IRRFs were not available for review for 7 of 10 individuals for whom APENs were submitted. The other two ate orally, so this metric did not apply. • --% of individuals who received enteral nourishment and were admitted since the last review (NA) had a review of the medical necessity of the feeding tube within 30 days. No one who received enteral nutrition had been admitted to LSSLC since the previous review. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • Neither of the two individuals who received enteral nutrition (Sample 0.3) were adequately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. The following metrics did not apply to this sample: • Individuals were identified as potentially benefitting from oral motor treatment and/or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process • Individuals' plans to return to oral eating were based on the results of the IDT's discussion and were integrated in the IHCP and the ISP or ISPA. • Individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. • Staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. The IDT met and interventions in the return to oral intake plans were reviewed and changed, as appropriate, in a timely manner. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA.	

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		• Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and positioning plan that addressed positioning during enteral intake only, rather than a Dining Plan. The monitoring team concurred with LSSLC's self-rating 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. Implement the established protocol and audit tool related to the process for assessment prior to tube placement. 2. Ensure completion of assessments, especially related to nutrition and oral motor, on an annual basis to contribute to the determination of the medical necessity of all individuals with enteral nutrition. 3. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF, and IHCP, as appropriate. 4. Establish clear support plans with clinical indicators for individuals with potential to return to oral intake and/or who would benefit from therapeutic intervention to address issues that may be barriers to return to oral intake.	

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 P QA Reports o OT/PT Policy and Procedures o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring templates o Completed Compliance Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Documentation of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Documentation of competency-based staff training submitted o PNM/Assistive Equipment Maintenance Log o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions

	○ OT/PT Assessment Tracking Log ○ Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to LSSLC: Individual #181, Individual #287, Individual #228, Individual #204, and Individual #313. ○ OT/PT Assessments, ISPs, ISPs, SAPs, and other documentation related to direct OT/PT supports for the following individuals: Individual #308, Individual #447, Individual #185, Individual #517, Individual #287, and Individual #192. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. ○ PNMP section in Individual Notebooks for the following: • Individual #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. <u>Interviews and Meetings Held</u>: ○ Danielle Perry, AuD, CCC-A, Habilitation Therapies Director ○ Various supervisors and direct support staff <u>Observations Conducted</u>: ○ Living areas ○ Dining rooms ○ Day programs

	Facility Self-Assessment: The self-assessment completed by Danielle Perry, AuD, CCC-A, Habilitation Therapies Director, was the best to date. The assessment was clear with relevant activities conducted. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently 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. Continued progress was noted, but improvements were still needed in the areas of quality and timeliness of assessments, monitoring, and direct intervention. The department leadership and the OT/PT staff appeared now on track with a plan to ensure that continued progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself not in substantial compliance with provisions P.1, P.2, P.3, and P.4 and the monitoring team concurred, except for P., which was found to be in substantial compliance. In order 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 the audit system promotes improvements in the content of OT/PT assessments at or near 90% which is the standard held by the monitoring team. The points identified in the following essential elements should be addressed with the clinicians: o Comparative analysis that clearly analyzed health status compared with previous years or assessments. o Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. The frequency of all monitoring should be clearly stated and in subsequent assessments, frequency and findings should be reported. o Comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was consistent with the previous review. o Discussion of the expansion of the individual's current abilities. o Discussion of the individual's potential to develop new functional skills. o Monitoring schedule. o Re-assessment schedule. Many assessments stated only that an assessment would occur as needed or upon a change in status, rather than annually based on service needs. o Detail the supports and services needed for successful community living. 2. The ACS should address essential findings from the last year, but should not be equivalent to a full comprehensive assessment. As described above, there should be a health and function comparison to the previous year, supports provided and the effectiveness of such, monitoring frequency and findings, with recommendations for the next year. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions.

	3. Review dates due and dates used to calculate timeliness and ensure that they are clearly stated and consistent. The appeared to be errors in calculation in the assessment log as submitted. 4. Rationale in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 5. 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. 6. 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. 7. Documentation for direct therapy must include an assessment (may be in the IPNs), integration into the ISP, and routine, thorough documentation, including a summary at least monthly, and a discharge summary with that reviews frequency, duration, outcomes of therapy and rationale for termination. 8. Establish a sound system for effectiveness monitoring of all aspects of OT/PT related supports and services to be conducted at least quarterly, or more often as indicated to meet individual needs. 9. Establish benchmarks, a tracking system and schedule for effectiveness monitoring by OTs and PTs. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 10. Establish and/or clearly document routine maintenance checks, integrating the compliance monitoring into this system.
	Summary of Monitor's Assessment: OT/PT assessments continued to improve. The essential elements section should be carefully reviewed so that content of some of the elements can be further refined. Further integration of OT/PT-related supports and services must be better integrated into the ISP. Supports introduced in the interim must be reflected via assessment and also be reflected in an ISPA. Documentation should consistently reflect generally accepted standards, and a monthly review of progress is essential. The monitoring team observed day program areas in which clear efforts to enhance the quality of those programs were evident. For example, a COTA was specifically assigned to the day program for that purpose. In addition, a Ladies Luncheon was established. It was clearly a success with the women who participated, and resulted in some very real changes in their level of participation and engagement. It was planned to expand this opportunity to others as well. The facility is commended for their ongoing support of these efforts. In general, however, the clinicians appeared to focus primarily on the provision of the PNMP supports rather than creatively looking at individual preferences and interests, as well as strengths to build programs and interventions that focused on minimizing barriers to participation, enhanced functional independence and promoted skill acquisition, in addition to addressing health and risk concerns. This should be the essence of therapy supports and services. Promoting health is essential as a foundation, but enhancing engagement, participation, and independence adds true quality to individual lives.

	Samples for Section P: • Sample P.1: 17 individuals for whom an individual record and the most current OT/PT/SLP assessment were submitted. • Sample P.1a: 12 individuals for whom an ISP and a most current assessment were submitted. • Sample P.2: 5 individuals newly admitted in the last six months for whom a current assessment was submitted. • Sample P.3: 6 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.	Assessments Assessments were appropriately completed per the ISP schedule. There was a tracking log of assessments completed for ISPs from 4/1/14 through 7/31/14, but it was not possible to track when the most current comprehensive assessment had been completed and whether the assessments documented were Comprehensive or Assessments of Current Status/Updates. The OTs and PTs completed a Comprehensive Assessment and/or an Assessment of Current Status/Update with the SLPs adding content related to mealtime/swallowing. The SLPs also completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status/Update as described in Section R below. At the time of this review, some changes had been made to the standard format for these reports (per the state office) and were to be in use as of 10/1/13. These included the following: All assessments should use the major categories (I – IX) in the order prescribed below; sub-headings can be added under the major headings depending on the content of the assessment. I. History II. Current Status (Diagnosis, Active Problem List, Risk Levels) III. Current Services (Medications, Treatments, Training, Supports) IV. Preferences, Strengths, Goals (from ISP Preparation meeting) V. Evaluation/Assessment Results VI. Additional Strengths, Contraindications to Stated Goals VII. Community Living/Services VIII. Summary IX. Recommendations The purpose for issuing a standardized assessment format was to ensure that important pieces of the assessment were present in each assessment, the components could be easily identified and located by other disciplines/staff, and to prepare for electronic health/life records. They also standardized the language for the Community Living/Services section.	Noncompliance

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		All individuals newly admitted to LSSLC were to be provided a comprehensive assessment or screening of OT/PT needs completed within 30 days of admission. Subsequent assessments were to be provided in the case that there was a significant change in status or special IDT request. An Assessment of Current Status was to be provided annually in the interim for individuals who received direct and/or indirect services in years. Based on the log submitted, timeliness for 107 assessments completed since 4/1/14 was 97%. Only one individual in Sample P.1 had a Comprehensive Evaluation current within the last 12 months (dates listed is the signature date): 1. Individual #174 (6/3/14) There were three OTs and three PTs, with a fourth OT recently hired, though only three were responsible for completing OT/PT assessments. Additional current assessments were submitted by each clinician. Some of these were duplicative across therapists, and some were submitted for staff no longer employed. For some who had recently begun employment, no assessments were submitted. This was likely due to the changes in contract personnel. These Comprehensive Assessments included the following: 1. Individual #142 (2/11/14) 2. Individual #106 (1/29/14) 3. Individual #147 (1/23/14) 4. Individual #128 (1/6/14) 5. Individual #598 (4/15/14) 6. Individual #204 (4/1/14) 7. Individual #228 (3/26/14 8. Individual #252 (3/26/14) 9. Individual #313 (4/7/14) 10. Individual #45 (11/20/13) 11. Individual #470 (1/22/14) 12. Individual #332 (3/12/14) 13. Individual #10 (4/2/14) 14. Individual #109 (3/25/14) 15. Individual #406 (2/25/14) The Assessment of Current Status was not considered a stand-alone evaluation, but rather served as an addendum or update to the previous Comprehensive Evaluation. Both should be contained in the individual record. The following individuals had Updates/Assessments of Current Status completed within the last 12 months and each had an associated Comprehensive Evaluation submitted and/or in the individual record: 1. Individual #545 (3/6/14) 2. Individual #294 (4/29/14)	

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		3. Individual #586 (12/29/13) 4. Individual #447 (5/27/14) There were no associated comprehensive assessments for the Assessment of Current Status for Individual #368, Individual #546, Individual #203, Individual #241, Individual #108, Individual #513, Individual #238, Individual #467, Individual #376, Individual #90, or Individual #185. Individual #507 had a comprehensive assessment dated 8/14/12, with no evidence of a subsequent Assessment of Current Status or update in 2013, as required, because she was provided OT/PT supports and services. <u>Timeliness of Assessments</u> Five individuals were admitted to LSSLC since the last review. A Comprehensive Evaluation was submitted for each of these. • 5 of 5 individuals in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the signature dates of the assessments submitted for review. The following metric was not applied because LSSLC did not use an OT/PT screening for individuals newly admitted to the facility, so no screenings were submitted for review: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening, received a comprehensive OT/PT assessment within 30 days of identification. There were 16 current OT/PT evaluations and ISPs submitted for Sample R.1 and an additional 12 submitted as current by clinicians (assessments for individuals newly admitted to LSSLC were not included, but rather timeliness for these was addressed above). Based on signature dates of the assessments reviewed, timeliness of the current OT/PT assessments (Comprehensive or Assessment of Current Status) was as follows: • 9 of 28 individuals' OT/PT assessments or updates (32%) were dated as completed at least 10 working days prior to the annual ISP. A number of these assessments were completed prior to 4/1/14 and were not included in the assessment log submitted. Four of the assessments found to be late by the monitoring team (completed less than 10 working days <u>prior</u> to the ISP) were identified as on time. It was not known if there were other discrepancies, though how the due dates were calculated and the assessment dates used for determining timeliness should be reviewed. As stated above the percentage for the most current assessments since that time was 97%. • 27 of 28 assessments (96%) were current within 12 months for individuals in Sample P.1 who were provided PNM supports and services. The exception was Individual #507.	

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		OT/PT Assessment Only current Comprehensive Evaluations included in Sample P.1 and P.1a were included in the following analysis (13). 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 assessments was as follows: • 11 of 13 assessments (85%) were signed and dated by both OT and PT clinicians upon completion of the written report. • 13 of 13 assessments (100%) included medical diagnoses. • 12 of 13 assessments (92%) included medical history. • 12 of 13 assessments (92%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. • 12 of 13 assessments (92%) addressed health status over the last year. • 9 of 13 assessments (69%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. • 13 of 13 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. While there was consistent discussion of existing risk levels with rationale and supports, there was very little to address the accuracy of these risk levels. For example, Individual #106 experienced at least one choking incident in the previous year, possibly two. He choked on a piece of ice and required the Heimlich. His choking risk was appropriately rated as high, though his aspiration risk was low. He had no reported history of aspiration or pneumonia. He required mealtime supports to prevent gulping, rapid pace of eating, and large bites. It would appear that he was also at risk for aspiration, though the clinicians did not identify this as a concern. In cases that clinicians concur with the existing risk ratings, this should be clearly stated. • 13 of 13 assessments (100%) listed medications and potential side effects relevant to functional status. • 13 of 13 assessments (100%) included individual preferences, strengths, and needs. These should be used to determine if existing functional levels supported, or were barriers to, participation in preferred activities. In the case of Individual #142, the clinicians stated that his preferences and strengths did not have a negative impact on his health and functional levels. Instead, a focus of the OT/PT assessment should be to promote improved access and participation in preferred activities and interests, remove or minimize barriers to this, and promote new or refined functional skills. • 12 of 13 assessments (92%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). In most cases, this appeared to be limited to mealtimes only, rather than observations in homes and day program areas.	

#	Provision	Assessment of Status	Compliance
		• 13 of 13 assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. • Twelve individuals required a wheelchair for some level of mobility. 12 of 12 assessments (100%) included a description of the current seating system with a rationale for each component and need for changes to the system were outlined as indicated, also with sufficient rationale. • 1 of 13 assessments (8%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. There was no routine compliance or effectiveness monitoring recommended in most cases and this was generally not implemented over the last year, so there was little to report. The frequency of all monitoring should be clearly stated. • 8 of 13 assessments (62%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was consistent with the previous review. When present, this was implied rather than clearly stated. • 12 of 13 assessments (92%) included documentation of how the individual's risk levels impact performance of functional skills. • 7 of 13 assessments (54%) included discussion of the expansion of the individual's current abilities. Most recommendations were related only to the PNMP. A rationale for why (or why not) the individual would benefit from interventions to expand or improve existing skills should be provided. • 5 of 13 assessments (38%) included discussion of the individual's potential to develop new functional skills. Most recommendations were related only to the PNMP. A rationale for why (or why not) the individual would benefit from interventions for skill acquisition should be provided. • 12 of 13 assessments (92%) 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. These were limited to indirect supports, such as the PNMP only, rather than for skill enhancement or acquisition. • 3 of 13 assessments (23%) included a monitoring schedule. • 5 of 13 assessments (38%) included a re-assessment schedule. • 13 of 13 assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. • 10 of 13 assessments (77%) detailed the supports and services needed for successful community living. This section should provide an overview of special indications that should be considered if the individual was going to transition to the community from the perspective of the OT and PT.	

#	Provision	Assessment of Status	Compliance

		• 13 of 13 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was generally limited to the PNMP only.
		
		A comparison of these elements was not reasonable because there was only one assessment for analysis during the previous onsite review. Further findings related to OT/PT assessments included:
		• No assessments contained 100% of the 23 elements listed above.
		• One assessment (Individual #598) met criteria (90% or greater) for the elements.
		• All other assessments were below criteria as follows:
		  • <90%=12
		  • <80%=10
		  • <70%=2
		
		The Assessment of Current Status was not considered a stand-alone evaluation, but rather served as an addendum or update to the previous Comprehensive Evaluation. Both should be contained in the individual record. The following individuals had Updates/Assessments of Current Status completed within the last 12 months and each had an associated Comprehensive Evaluation submitted and/or contained in his or her individual record:
		• Individual #545 (3/6/14)
		• Individual #294 (4/29/14)
		• Individual #586 (12/29/13)
		• Individual #447 (5/27/14)
		
		There were no associated comprehensive assessments for the Assessment of Current Status for Individual #368, Individual #546, Individual #203, Individual #241, Individual #108, Individual #513, Individual #238, Individual #467, Individual #376, Individual #90, or Individual #185. Individual #507 had a comprehensive assessment dated 8/14/12, with no evidence of a subsequent Assessment of Current Status or update in 2013, as required, because she was provided OT/PT supports and services.
		
		There were 15 individuals in Sample P.1 and P.1a for whom records were submitted with current Updates/Assessments of Current Status, and four had associated Comprehensive Assessments submitted and/or contained in the records as described above.
		• For 13 of 15 individuals for whom Updates/Assessments of Current Status were completed (87%), 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	

#	Provision	Assessment of Status	Compliance
		and re-assessment schedules. The most commonly omitted element was related to monitoring. Occasionally, there was reference to this in the body of the report, but it was not identified as a recommendation at the end of the report. There was a self-audit system in place involving review of all assessments. By report, there were plans to move this to a peer reviewed, with a sample of outside review by the Habilitation Therapy consultant. This provision was self-rated to not be in substantial compliance and the monitoring team concurred. Very few individuals received direct therapy services, though documentation related to this was generally within standard practice. 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 the audit system promotes improvements in the content of OT/PT assessments at or near 90% which is the standard held by the monitoring team. The points identified in the following essential elements should be addressed with the clinicians: • Comparative analysis that clearly analyzed health status compared with previous years or assessments. • Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. The frequency of all monitoring should be clearly stated and in subsequent assessments, frequency and findings should be reported. • Comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was consistent with the previous review. • Discussion of the expansion of the individual's current abilities. • Discussion of the individual's potential to develop new functional skills. • Monitoring schedule. • Re-assessment schedule. Many assessments stated only that an assessment would occur as needed or upon a change in status, rather than annually based on service needs. • Detail the supports and services needed for successful community living. 2. The ACS should address essential findings from the last year, but should not be equivalent to a full comprehensive assessment. As described above, there should be a health and function comparison to the previous year, supports provided and the effectiveness of such, monitoring frequency and findings, with recommendations for the next year. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions. 3. Review dates due and dates used to calculate timeliness and ensure that they are	

#	Provision	Assessment of Status	Compliance
		clearly stated and consistent. The appeared to be errors in calculation in the assessment log as submitted.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>Direct OT/PT Interventions:</u> There were 12 individuals listed as participating in direct OT and/or PT and six were included for review in Sample P.3 (Individual #308, Individual #447, Individual #185, Individual #517, Individual #287, and Individual #192). • For 3 of 6 individuals (50%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale. • 3 of 6 individuals had direct intervention plans (50%) implemented within 30 days of creation or sooner as indicated by the individual's health and safety. There were no clear intervention plans other than a list of goals in an assessment IPN for some individuals. All documentation was in the IPNs, but few made reference to the intended outcomes of therapy in measurable terms. • For 0 of 6 individuals (0%), there were objectives related to functional individual outcomes included in the ISP or ISPA. Objectives were listed in IPNs in some cases, though there was limited reference to progress related to these on a routine basis. • For 2 of 3 individual (67%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Progress notes/IPNs: • 0 of 6 individuals receiving direct OT/PT Services (100%) were provided with comprehensive progress notes (IPNs) at least monthly that contained each of the indicators listed below: 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), including frequency and duration of therapy; 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. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format, content and integration into the ISP and section S for skill acquisition plans. Implementation of PNMPs is addressed in section O.5.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Integration of OT/PT Interventions, Supports and Services in the ISP Review of the PNMP and Dining Plans were required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the OT and/or PT clinicians. As described above, the ISPs or ISPAs for individuals in the sample who participated in direct OT or PT services did not consistently establish the need to begin or terminate therapy. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. Pre-ISP documentation and ISPs were requested for individuals included in Sample P1. Pre-ISP required attendance sheets were submitted for only three individuals (Individual #203, Individual #507, and Individual #376). Individuals included in sample P.1a were not included below as the ISPs for those individuals were not submitted in whole, but rather only the assessment portion. Review of the ISPs submitted was as follows: • 100% (21 of 21) of the ISPs submitted were current within the last 12 months • 100% (21 of 21) of the current ISPs had attached signature sheets. • 14% (3 of 21) of the current ISPs with signature pages submitted were attended by both the OT and PT (Individual #118). • 43% (9 of 21) were attended by PT only. • 33% (7 of 21) were attended by OT only. • 10% (2 of 21) of the current ISPs had no representation by an OT or PT (Individual #308 and Individual #586). Per their assessments, both had OT/PT-related needs. Of the three individuals for whom pre-ISP required attendance sheets and ISP signature sheets were submitted, each designated required attendance by PT. In two cases, a PT representative was present (Individual #203 and Individual #376). In the case of Individual #507, a PT did not attend, but rather an OT was present. The facility needs to clearly establish a rationale for attendance by all team members 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. This element was self-rated to not be in substantial compliance and the monitoring team concurred. Very few individuals received direct therapy services, and documentation related to this was generally within standard practice, with the exception of monthly summaries to address progress by the clinician. To continue to move in the direction of	

#	Provision	Assessment of Status	Compliance
		substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 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. 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. 4. Documentation for direct therapy must include an assessment (may be in the IPNs), integration into the ISP, and routine, thorough documentation, including a summary at least monthly, and a discharge summary with that reviews frequency, duration, outcomes of therapy and rationale for termination.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Competency-Based Training</u> Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs were addressed in detail in section O.5 above. Substantial compliance with O.5 is the standard for compliance with this element.	Substantial Compliance
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	The facility had a current OT/PT policy and very detailed procedures that addressed the following: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Identification of monitors and their roles and responsibilities; • Definition of a formal schedule for monitoring to occur; • Process for re-evaluation of monitors on an annual basis by therapists and/or assistants;	Noncompliance

#	Provision	Assessment of Status	Compliance
	of these interventions.	• Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identification of the frequency of assessments; • Definition of how individuals' OT/PT needs will be identified and reviewed; and • Requirements for documentation for individuals receiving direct services. <u>Monitoring System</u> The facility had recently implemented a system for the adequate monitoring of PNMPs conducted by the PNMPCs. This included staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment. The standardized system for compliance monitoring of the PNMPs and Dining Plans consisted of a determination of frequency by the Habilitation Therapy Director based on risk levels and established thresholds in each area. This was generally conducted by the PNMPCs. The review findings related to this were discussed in section O.6 above. A sound system for effectiveness monitoring by the therapy clinicians had not yet been established and should be a focus over the next six months. Effectiveness monitoring guidelines should indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale • Based on the monitoring team's direct observation of over 50 individuals, over 90% of positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. • Based on review of the maintenance log, individuals for whom adaptive equipment was noted to be in disrepair or needing replacement, equipment was repaired or replaced within 30 days, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours. It could not be determined if all equipment was checked at least quarterly for presence and condition related to the compliance and effectiveness monitoring systems. This was to be addressed through the compliance monitoring system, but as not all individuals would be monitored routinely, an additional system related to equipment may be needed. This element was self-rated to be 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. Establish a sound system for effectiveness monitoring of all aspects of OT/PT	

#	Provision	Assessment of Status	Compliance
		related supports and services to be conducted at least quarterly, or more often as indicated to meet individual needs. 2. Establish benchmarks, a tracking system and schedule for effectiveness monitoring by OTs and PTs. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 3. Establish and/or clearly document routine maintenance checks, integrating the compliance monitoring into this system.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o DADS Policy #15.1: Dental Services, 8/15/13 o LSSLC Dental Procedures Manual, 5/31/13, revised 5/15/14 o LSSLC Procedures Manual, Use of Restraint, 4/29/14 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 Comprehensive Annual Dental Assessments for the following individuals: o Individual #598, Individual #407Individual #492, Individual #351, Individual #118, Individual #82, Individual #374, Individual #544, Individual #114, Individual, #97 o Complete dental/anesthesia records for the following individuals: o Individual #192, Individual #430, Individual #477, Individual #423, Individual #245, Individual #380 o Oral Surgery Consultations for the following individuals: o Individual #228, Individual #526, Individual #375 o Dental Clinic Task Analysis, Dental Desensitization Assessment Forms, and IPNs for the following individual: o Individual #93, Individual #566, Individual #55, Individual #221, Individual #101, Individual #147, Individual #285, Individual #385 o Dental Records for the following individuals from Section L1 record sample: o Individual #517, Individual #382, Individual #357, Individual #450, Individual #502, Individual #170, Individual #59, Individual #337, Individual #121, Individual #299 <u>Interviews and Meetings Held</u>: o Ahmad Jafri, DDS, Dental Director o Tina Murray, DDS, Facility Dentist o JoAnne Lancaster, RDH o Melissa Dalton, RDH o Francis Tucker, RDH o Nancy DeVore, Dental Clerk o Andra Self, Clinical Services Director

	○ Robin McKnight, Behavioral Health Services Director <u>Observations Conducted</u>: ○ Dental Clinic ○ Informal observation of oral hygiene regimens in residences ○ 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: The dental clinic continued to make progress under the direction of the dental director. The staff was a dedicated group of individuals who understood their roles in the delivery of dental services. They remained enthusiastic about their work, the progress that was made, and the opportunity to provide additional services. A number of new initiatives were in the process of being implemented to improve oral health. A periodontal program was developed to address individuals with moderate to severe periodontitis. The suction toothbrushing program was expanded to treat more at-risk individuals. The clinic staff was conducting oversight of this program. The hygienists and the dentists conducted random observations in the homes. Training was expanding through demonstration done by the dentist as well as the development of a new suction toothbrushing video. The completion of radiographs increased and the clinic had acquired portable equipment that allowed even more individuals to have the necessary radiographs. Individuals were followed in clinic based on their overall oral health. Individuals with poor oral hygiene and those with moderate or severe periodontitis were seen every three months. All individuals were seen at least every six months. The processes, training, and oversight appeared to have a positive impact. The percentage of individuals with good hygiene increased while the percentage of individuals with poor hygiene decreased by half. The facility had a relatively low failure rate. Most of the failed appointments were due to refusals. The dental clinic collaborated with behavioral health services to address barriers to dental treatment. The

	clinic notified the behavioral health services department with individuals refused treatment or when individuals had poor oral hygiene believed to be associated with behavior. The behavioral health services assistance attended clinic with those individuals and completed a dental task analysis when appropriate and dental desensitization assessment was completed. The monitoring team saw evidence of this process. At the time of the compliance review, it was reported that 29 individuals had been assessed. However, documentation for all individuals who were referred for assessment was not available. The approach seemed to be a reasonable one, but it did not appear to capture all individuals who were in need of assessment. The monitoring team found examples of individuals who refused treatment and who appeared to have poor oral hygiene associated with behavior that were not on the list of 29 individuals. The facility will need to make more progress in this area. Overall, the records reviewed indicated that most individuals were receiving timely treatment with most having frequent assessments and treatment. Individuals with poor hygiene status and periodontitis were having frequent assessments and receiving additional supports. The facility was addressing refusals and other barriers to treatment through collaborative efforts with the Behavioral Health Services Department. However, the facility did not have sufficient documentation for the individuals reviewed to support that the program was effective.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with 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. The part-time hygienist both worked two days a week. The clinic now had two hygienists working Monday through Thursday. <u>Annual Assessments</u> Annual Assessment Compliance 2014 | | Jan | Feb | Mar | Apr | May | | No. of Exams Completed | 30 | 34 | 15 | 19 | 28 | | % Timely Completion | 86 | 85 | 80 | 78 | 100 | The monitoring team requested a list of annual assessments completed in the last six months, listed by month. Five months of data were submitted. Per state guidelines, annual assessments were required to be completed within 365 days of the prior	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		assessment. The compliance rate for timely completion was 85%. The compliance rate for the last review period was 88%. Ten comprehensive exams (the Annual Dental Examinations) were submitted for review. The facility utilized a single template for all examinations. It was updated to include all the requirements of the state template. 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, positioning, 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. There was improvement in the documentation of the types of oral hygiene instructions that were provided. Treatment recommendations were more specific. The date of the last radiographs and the findings were being documented. One of the 10 examinations reviewed was incomplete and lacked the periodontal assessment and oral cancer exam. Overall, the dental examinations were thorough and complete. Even so, there were a few aspects of the assessments that should be addressed: • Legibility of the written component was a concern for some assessments. • The area for "treatment rendered " appeared to be rather limited and there was often documentation by more than one provider based on handwriting differences. The monitoring team noticed that not all providers were documenting essential information, such as the type of local anesthesia used when fillings and extractions were completed. This is basic information that should always be documented. • It was difficult to sometimes to know why the individual was in clinic. The second column of the IPN was used to document that. Comments such as "referred to clinic for pain" or "referral evaluation" were noted. The second column of the IPN should generally indicate the discipline or type of practitioner (DDS or RDH). <u>Initial Exams</u> Six 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 for January 2014 to May 2014 were submitted.	

#	Provision	Assessment of Status	Compliance

Oral Hygiene Ratings (%)				
Compliance Round	OH Assessments	Good	Fair	Poor
8	562	56	29	15
7	650	47	17	36
6	646	33	22	45

These data indicated that overall hygiene ratings in the facility were improving. A number of processes were implemented to improve the oral hygiene of the individuals:

- Individuals with good hygiene were placed on a 6-month recall schedule. Individuals with fair hygiene were seen every 4 months. Individuals with poor oral hygiene were seen every 3-months until hygiene improved.
- Oral hygiene instructions were reviewed with the individual and DSP who accompanied the individual to clinic.
- A demonstration for all employees was provided in the homes by the dental director. It emphasized proper seating and techniques for effective toothbrushing and oral care.
- When an individual was determined to have poor oral hygiene during a clinic visit, a report was sent to the unit director, residential services director, director of habilitation services, and the director of behavioral health services in order to implement a plan to improve oral hygiene.
    - If the poor oral hygiene was attributed to the individuals behavior, BHS was contacted for assistance.
    - Individuals with poor hygiene were assigned a high-risk rating and were considered candidates for TIVA on a 6-month recall for deep scaling and maintenance of periodontal pockets.
- Behavioral health services conducted assessments for individuals whose poor oral hygiene was associated with refusing treatment.
- Since periodontal disease was identified as the greatest concern for individuals at the facility, a periodontal program was implemented.
    - Individuals were followed based on the severity of disease. A number of new interventions and therapeutic options were being explored.
    - Individuals with moderate to severe disease were recommended for desensitization plans, continuous monitoring, and SAPs.

<u>Suction Toothbrushing</u>

Primary care providers identified individuals with a history of recurrent pneumonia, excessive sputum production, and dysphagia who could potentially benefit from suction toothbrushing. The program was coordinated through the medical department.

#	Provision	Assessment of Status	Compliance
		Eighty-seven individuals received suction toothbrushing. Direct support professionals provided the treatment. Nursing staff applied chlorhexidine twice daily. Competency based training was provided in New Employee Orientation. The dental department and CTD collaborated to produce a training video demonstrating proper use and maintenance of suction toothbrushing equipment. Following approval by state office, the video would be made available through iLearn for refresher training. The dental department and habilitation services were providing oversight of suction toothbrushing with unannounced home checks. Equipment was checked and the provision of oral care was observed. Problems identified through these observations were referred to the unit managers. Chlorhexidine was used on a two-week schedule. The recommendation from the monitoring team for <u>non-continuous</u> chlorhexidine use was based on draft state policy and discussions with the state dental coordinator that occurred during several onsite reviews. It should be noted that the FDA issued a warning letter regarding the use of chlorhexidine stating, "An increase in supragingival calculus was noted in clinical testing in Peridex Oral Rinse users compared with control user. It is not known if Peridex use results in an increase in subgingival calculus. Calculus deposits should be removed by a dental prophylaxis at intervals not greater than 6 months." The warning further stated that "Peridex can cause staining of oral surfaces, such as tooth surfaces, restorations, and the dorsum of the tongue. Stain will be more pronounced in those who have heavier accumulation of unremoved plaque." The dental director should seek further guidance from the state dental services coordinator regarding the continuous use of chlorhexidine. <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. The total number of clinic visits and key category visits are summarized below. Clinic Appointments 2014 Jan / Feb / Mar / Apr / May Preventive: 26 / 60 / 69 / 147 / 77 Emergency: 0 / 0 / 0 / 0 / 0 Extractions: 2 / 2 / 4 / 1 / 2 Ext (Off-Campus): 0 / 0 / 1 / 0 / 0	

#	Provision	Assessment of Status	Compliance

Restorative	3	4	4	2	4
Total Appointments	83	110	110	205	153

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.

Radiographs

The dental director reported that the ADA's guideline to obtain radiographs every two years was being followed unless the dentist determined otherwise. A draft policy for obtaining radiographs was developed, but had not been approved at the time of the compliance review. Based on this standard, 62% of the average census for the monitoring period had current radiographs per the document submission. This increased to 70% at the time of the compliance review. The dental clinic had recently obtained a portable x-ray machine, which allowed individuals to have x-rays done in their specialized seating. The use of specialized seating sometimes prohibited staff from obtaining x-rays with the clinic's wall machine.

For the 10 individuals included in the record sample, 6 of 10 (60%) had documentation of current radiographs. It was recommended that 3 of 10 (30%) individuals have treatment and examination with TIVA, which would allow the radiographs to be obtained. There was no documentation of radiographs or plan to obtain radiographs for Individual #450. The individual had been chronically ill and been hospitalized multiple times.

Oral Surgery

The oral surgeon who saw individuals now had an office located in Lufkin. Three individuals were referred to the oral surgeon for treatment. The consults for those individuals were reviewed. The facility submitted the initial consults, but documents related to the actual treatment were not included. Two evaluations were for extractions. The third was for a fracture of the maxilla.

Sedation/General Anesthesia/TIVA

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 continued. A meeting was conducted on Tuesdays and Thursdays to discuss the most appropriate medications, risks, and

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		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 facility continued to track the use of oral sedation and TIVA. Those data are summarized below.	

General Anesthesia and Sedation 2014					
	Jan	Feb	Mar	Apr	May
TIVA	7	8	8	8	8
Oral Sedation	2	1	1	3	2
Off Campus	0	0	1	0	0
Total	9	9	10	11	10
Total Appointments	83	110	110	205	153

The dental director explained that the contract anesthesiologist was ACLS and PALS certified and brought a fully stocked crash cart to the center each month as part of the anesthesia equipment. 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. Vital sign flow sheets, react scores, and nursing IPN documentation were found for all individuals. The facility did not submit the anesthesia records.

The dental director revised the Dental Services Policy to include additional information on the use of TIVA. The names of individuals who needed TIVA were submitted to the contract anesthesiologist along with the medical records. It the anesthesiologist determined that the individuals were suitable candidates, the dentist submitted a TIVA consultation report for review and recommendations by pharmacy, psychiatry, and the primary care provider regarding the anesthesia and the treatment for the individual. The completed consultation report was reviewed by the clinical services committee and a consensus on the proposed treatment was determined. Per the Dental Services Policy, the anesthesiologist took the recommendations and conclusions of the consultation report and the clinical services committee into consideration. The completed consultation report was provided to the QIDP for review by the IDT. The dental clinic provided documentation for the justification of the use of TIVA. The IDT had the option to concur with the recommendation or suggest other viable options.

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		There was still a need to develop policy and procedure that provides additional detail on the scope of sedation that could be utilized at the facility and the process for determining candidates for these services. The Dental Services Policy continued to have guidelines for the use of intramuscular medications for sedation (not associated with TIVA). This implied that the facility allowed conscious sedation. LSSLC is a Basic Life Support (BLS) level facility and, therefore, conscious sedation should not be performed. The facility did not maintain the equipment required for that level of sedation and the nursing and medical staff was not required to have Advanced Cardiac Life Support (ACLS) training. A draft policy addressing some of these issues was developed, but not approved at the time of the compliance review. The monitoring team strongly recommends that the development of any policies and procedures related to the use of sedation involve the medical leadership of the facility. The state medical and dental services coordinators should also be consulted. <u>Staff Training</u> All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn. Annual training was mandatory. 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. There continue to be areas that require attention, such as improving radiograph compliance, assessment documentation, and development of additional guidelines related to TIVA.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions;	<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 general operations of the clinic, staffing, informed consent, sedation, oral care, infection control, and training. The manual was revised 5/15/14. Revisions were limited to section J, which addressed the use of TIVA. A series of drafts to the dental services policy was also submitted. Those revisions addressed sedation, desensitization, suction toothbrushing training, and sterilization. New policies on radiographs, selection criteria for TIVA, and periodontitis were also being added. Those revisions and additions were dated 2014 and had not been approved at the time of the compliance review.	Noncompliance

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	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.	Dental Records Dental records consisted of IPN entries, Annual Dental Examinations, Annual Dental Summaries, and odontograms. Improvements were noted in the dental documentation. Legibility of some documentation was a concern. This was seen particularly when information was entered into restricted spaces. There were some notes that included the signature of the hygienist, but lacked the signature of the dentist even though it was clear that the dentist had rendered treatment. Overall, dental documentation was adequate. Failed Appointments The guidelines issued by state office required reporting of missed/no show appointments and refusals. 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:	

Failed Clinic Appointments 2014					
	Jan	Feb	Mar	Apr	May
Missed/No show	3	0	4	6	1
Refused	7	9	11	18	18
Failed	10	9	15	24	19
% Failed	12	8	13	11	12
Total Appointments	83	110	110	205	153

For the 14 missed appointments documented for the reporting period:

- 3 of 14 (21%) were due to hospitalization
- 6 of 14 (42%) were due to illness
- 2 of 14 (14%) were due to inclement weather
- 2 of 14 (14%) were due to furlough
- 1 of 14 (7%) was due to conflicting appointment

Overall, the number of missed appointments was very small. When appointments were missed, they were usually re-scheduled without significant delay.

Strategies to Overcome Barriers to Dental Treatment
The refusal rate for the reporting period was 9.5%. This was a slight increase from the 7.6% noted during the last compliance review. The monitoring team met with the dental and behavioral health services directors to discuss the facility's approach to addressing refusals and other barriers to dental treatment.

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		The dental clinic notified the behavioral health services department when individuals were identified to be in need of assessment. The behavioral health services director reported that BHS assistants attended clinic appointments with individuals who had a history of refusals, poor hygiene, and moderate to severe periodontitis. A dental task analysis was completed for the 29 identified individuals. The task analysis and desensitization forms were formatted as IPN notes. The task analysis was the third page of the dental IPN. It was explained that the goal was to have behavioral health services complete the process for all individuals who required pretreatment sedation or TIVA, recognizing that desensitization may not be appropriate. In addition to the aforementioned process, the Dental Outreach Program continued to provide informal desensitization by allowing dentists and hygienists to conduct assessments and provide some treatment in the individual's home environment. The home visits occurred on Wednesday mornings. A list of 29 individuals was submitted. The monitoring team randomly selected eight individuals for review. Dental IPNs, task analysis, and dental desensitization assessment forms were requested. IPNs were submitted for all individuals. However, the other assessments were submitted for only three individuals as noted below: • Individual #221 had a preference assessment completed and dental desensitization assessment (5/13/14). • Individual #101 had a task assessment completed on 3/19/14 and a dental desensitization assessment completed on 4/2/14. • Individual #147 had a task analysis completed on 2/19/14. The IPN documentation for four individuals included a statement by dental staff that behavioral health services was being contacted or assistance was requested. Three of the four individuals had information of assessments documented. The fourth individual did not have documentation of assessment by behavioral health services, but successfully completed a home evaluation. Individual #385 did not have documentation of a task assessment, but the dental IPN noted that the behavioral health assistant and brother both attended the clinic appointment. The monitoring team identified individuals in the record sample who appeared to need assessment. For example, Individual #502 was seen in clinic on 7/2/14 and was uncooperative. The IPN noted that assistance would be sought from behavioral health services, however, there was no documentation of assessment provided. While the director of behavioral health services reported that task assessments were completed for the 29 individuals, documentation of those assessments was not provided	

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		for the majority of individuals in the random sample. LSSLC's approach appeared to be a reasonable one. However, the records and documentation reviewed did not provide evidence that this process was implemented to the extent reported. The monitoring team found this provision to be in noncompliance. There was insufficient documentation of the system that was described. The dental clinic did not document that assistance was sought from psychology in cases were it appeared that the criteria for requesting help were met. Moreover, the monitoring team requested documentation for eight individuals as evidence that assessments occurred as reported. The facility submitted adequate documentation for only three individuals. The dental department also needs to complete the process of policy revision to address some key issues such as TIVA and the scope of sedation used in the facility. <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 dental director should address the need to add additional topics to the dental manual. 2. The behavioral health department must continue to expand the list of individuals that are in need of services. Documentation of actions taken such as completion of the task analysis and desensitization assessment forms must be maintained.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Section R QA Reports o Current SLPs, license numbers, ASHA 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 individuals with PBSPs o Master Plan o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment 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 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 o Communication/Compliance Monitoring forms submitted o Summary reports or analyses of monitoring results o Staff training data submitted o Communication Assessments, ISPs, ISPAs, SAPs, intervention plans, IPNs, and other documentation related to communication for the following individuals: • Individual #410, Individual #192, Individual #33, Individual #227, Individual #20, Individual #535, Individual #182, Individual #267, Individual #598, Individual #128, Individual #418, Individual #337, and Individual #220. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, 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 #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. o PNMP section in Individual Notebooks for the following:

	• Individual #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #545, Individual #513, Individual #368, Individual #467, Individual #376, Individual #185, Individual #586, Individual #108, Individual #203, Individual #546, Individual #174, Individual #241, Individual #507, Individual #294, Individual #238, Individual #447, and Individual #90. <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 Megan Melton, MS, CCC-SLP o Audrey O'Berry, SLPA o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs
	Facility Self-Assessment: The self-assessment completed by Danielle Perry, AuD, CCC-A, Habilitation Therapies Director, was the best to date. The assessment was clear, with relevant activities conducted. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of the elements were addressed and used to determine compliance. Findings were consistently 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. Continued progress was noted, but improvements in the areas of assessments, monitoring, and direct intervention were at too slow a pace to be acceptable. The department leadership and the speech staff appeared now on track with a plan to ensure that progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself not in substantial compliance with provisions R.1, R.2, R.3, and R.4 and the monitoring team concurred. LSSLC supported a significant number of individuals with severe communication deficits and, as such, it is critical that caseloads be

	sufficiently smaller to ensure that adequate and appropriate supports are provided. In order 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 and implement an aggressive plan for the completion of communication assessments and/or screenings as appropriate. This plan should ensure that existing supports and services are not neglected. Specific benchmarks for completion must be clearly established and met in a timely manner. 2. Further coaching and monitoring of speech clinicians will be necessary to maintain compliance with the essential elements for communication assessments. Weaknesses, particularly related to AAC assessments, should be addressed for some clinicians. 3. Ensure that the information in the communication assessment related to the PBSP is well integrated. Ensure that the communication strategies are effectively translated into the PBSP and consistent with the individual's communication function and methods of communication. 4. Ensure that information related to communication is effectively translated to the ISP. 5. Address the consistency and necessary elements of documentation of direct interventions. 6. Develop and implement annual refresher training in the area of communication for existing employees 7. Review the consistency and accuracy of communication monitoring. 8. Many of the assessments reviewed recommended monthly monitoring, but did not necessarily distinguish between compliance monitoring and effectiveness monitoring and this should be clearly established. 9. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines to enhance consistency. Consider use of an IPN to further document these findings. 10. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment or other established guidelines. Ensure that these findings are included in annual communication assessments for individuals.
	Summary of Monitor's Assessment: There was an exceptional team of speech pathologists and the addition of the SLPA was excellent. While the clinicians continued to be successful in the development of communication supports, the continued delay in completion of communication assessments, and in a timely manner relative to the ISP must be corrected. During this onsite review, there appeared to be the foundation for a plan in development to remedy this, but they must get it done as quickly as possible. An appropriate annual ISP cannot be developed in the absence of the necessary communication information required for an integrated plan. There were a tremendous number of communication systems in place, though integration of communication supports were not consistently integrated into the ISPs. Though improved, there was insufficient evidence that there was discussion related to the supports provided and their effectiveness.

	Generally, sections from the communication assessment were inserted into the ISP. There are key aspects of section R that require evidence of integration into the ISP annually and during interim ISPAs. This must include actual documentation that the IDT reviewed the communication dictionary, communication plans, and supports, and that the IDT specifically identified the effectiveness and any need for changes. The facility should consider implementation of a peer review process to ensure that all clinicians continued to refine their assessment skills, particularly related to the need for AAC and environmental control. Consistency of documentation of direct supports and review of indirect supports was needed. Compliance monitoring focused primarily on the equipment, rather than also the implementation of supports. Effectiveness monitoring should reflect a review of all communication supports at least on a quarterly basis. <u>The following samples were used by the monitoring team:</u> • Sample R.1: 17 individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals with AAC systems selected by the monitoring team • Sample R.4: Individuals receiving direct speech services (9)

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	<u>Staffing</u> There were three full time SLPs with responsibilities related to communication and one SLPA (Audrey O'Berry). They were Kristi Hodges, MA, CCC-SLP, Chris Pedroni, MA, CCC-SLP, and Maegan Melton, MS, CCC-SLP. The facility document that listed budgeted and filled positions identified six budgeted positions for SLPs that were filled at the time of this review. This included the three SLPs responsible for mealtime/dysphagia concerns and did not include the SLPA. FTEs were calculated as six, with a ratio of 1:55. Based on the reported census of 328, the current ratio for clinicians responsible for communication was actually approximately 1:109, nearly double that reported by the facility. The SLPA is not considered as a part of this ratio because assessment was not a permitted scope of her practice, but rather she served a key role to assist and support the SLPs and was licensed to provide direct intervention related to communication. Responsibilities of the full-time communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, attendance at ISPs and ISPAs, and monitoring the implementation of programs related to communication and dysphagia. The full-time SLPs provided supervision to the SLPA, as well as mentoring and training to the Habilitation Therapy technicians to enhance their competency in the monitoring of communication supports and services.	Noncompliance

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		The speech staff were assigned caseloads as follows per the documentation submitted: • Kristi Hodges: Her communication-related responsibilities included Homes 520B, 523, and Woodland Crossing, and supervision of the SLPA. • Chris Pedroni: Her communication-related responsibilities included Homes Castle Pines and supervision of the SLPA. • Maegan Melton: Her communication-related responsibilities included Homes 520A, 524, and Castle Pines, and supervision of the SLPA. • SLPA: Full-time responsibilities included assisting the SLPs as assigned. Per the self-assessment, the facility had identified the clinician caseloads as varying from 200 in January 2014 to 71 in May 2014 (e.g., for Kristi Hodges). In other months, caseloads were listed as 0, based on absences for therapists. As of May 2014, it appeared that only 143 individuals were considered to be on caseload for two clinicians, though the census was listed as 332. The facility was encouraged to maintain consistency for responsibility of caseload assignments even when a clinician was on extended leave. The individuals did not leave the facility and continued to present with communication needs. Per the Master Plan still in use by the facility, there were 116 individuals listed as Priority 1 (nonverbal with PBSPs), 108 individuals who were nonverbal without PBSPs, 60 individuals listed as Priority 3 (limited speech), and the remainder were listed as Priority 4 (communicated without difficulty). This comprised approximately 86% of the existing census of the facility with communication needs at the time of this onsite review. It was not clear why, then, there were only 143 individuals listed on caseload as of May 2014. This left at least another 141 individuals not assigned a therapist for supports and/or services. Because a large majority of these individuals at LSSLC had not yet been assessed or screened (245 individuals), the extent of their specific needs were not known, regardless of their assigned priority ranking. Based on the projected needs for individuals with communication deficits identified in the Master Plan, the caseload ratio for three clinicians was approximately 1:95. This was too high to ensure that individual communication needs were appropriately met. Staffing had remained stable since the previous onsite review, though extended absences by some clinicians significantly stretched existing resources. At three FTEs and one SLPA, LSSLC did not provide an adequate number of speech language pathologists with specialized training or experience to provide communication supports and services based on the ratio identified above. <u>Qualifications:</u> • The facility documented appropriate qualifications for licensed SLPs. • 4 of 4 speech staff, with responsibilities related to communication (100%) were	

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		currently licensed to practice in Texas as verified online. This was consistent with the previous review. • 3 of 3 speech staff, with responsibilities for communication (100%) held current ASHA certification. This was consistent with the previous review. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 4 of 4 current speech staff responsible for communication supports and services (100%) had completed continuing education in the last year, though none of this was in the last six months. This was consistent with the previous review. Specific courses and relevance to communication could not be determined. 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 or DADS-sponsored courses 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. There was a local policy related to communication (Revised, 4/22/14). The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services. Each of the following elements was sufficiently addressed in the policy in conjunction with other procedural documents and a well-established procedure was currently in practice: • 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. • Methods of tracking progress and documentation standards related to intervention plans. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as,	

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		problem resolution. Though the existing staff were well qualified and experienced, there appeared to be an insufficient allocation of speech staff resources, based on the current census and identified need. The current staff ratio and caseload sizes were high at the time of this review. Limitation to caseload size is critical to ensure that clinicians are able to complete assessments in a timely manner, provide appropriate direct interventions, provide sufficient training (including modeling and coaching) for the implementation of communication programs, and to adequately maintain the necessary equipment. Further, there was a significant backlog of assessments that remained incomplete. Though clearly these clinicians had excelled in the provision of meaningful and effective communication systems for a number of individuals, the need to move forward with an aggressive plan for completion of assessments and/or screenings was needed. The monitoring team concurred with the self-assessment of noncompliance. In order 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 and implement an aggressive plan for the completion of communication assessments and/or screenings as appropriate. This plan should ensure that existing supports and services are not neglected. Specific benchmarks for completion must be clearly established and met in a timely manner.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>Assessment Plan:</u> Assessments were not appropriately completed per the ISP schedule, change in status, or per IDT request. The facility maintained a Master Plan that outlined the completion of comprehensive assessments and interim updates, but did not include projected subsequent interim updates and additional comprehensives. This also served as the assessment tracking log. As noted previously, the SLPs at LSSLC were to complete either a Comprehensive Communication Evaluation and/or an Assessment of Current Status. At the time of this review, some changes had been made to the standard format for these reports per the state office and were in use as of 10/1/13. There was discussion of more extensive use of a strong screening to more quickly identify needs for individuals newly admitted or who had previously been identified as Priority 4 for communication needs. In any case that communication needs were identified during the course of a screening, the clinician would be expected to complete a comprehensive within 30 days. All individuals newly admitted to LSSLC were to be provided a screening of communication skills completed within 30 days of admission. As described above, in the	Noncompliance

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		case that communication needs were identified, a comprehensive assessment was to be completed within 30 days. An Assessment of Current Status was to be provided annually in the interim for individuals who received direct, were provided AAC, or who had received a comprehensive assessment in the last five years (per the policy submitted). Assessment due dates and timeliness of completion were maintained in the Master Plan. <u>Assessments Provided</u> Communication assessments for individuals in Samples R.1 (17 individuals) and R.4 (nine individuals) were submitted as requested (exceptions included Individual #513, Individual #368, Individual #467, Individual #108, Individual #546, and Individual #238): Speech Language Evaluation 1. Individual #241 (10/1/13) 2. Individual #185 (7/30/13) 3. Individual #294 (4/28/14) 4. Individual #20 (10/22/13) 5. Individual #182 (11/13/14, presumed to be 11/13/13) Speech Language Comprehensive Assessment 1. Individual #447 (4/26/12) 2. Individual #410 (12/13/14, presumed to be 12/13/13) 3. Individual #90 (4/23/14) Communication Skills Evaluation 1. Individual #447 (4/13/12) Communication Skills Evaluation - Update 1. Individual #203 (9/30/09) 2. Individual #545 (4/16/07) 3. Individual #174 (7/24/08) 4. Individual #241 (11/13/08) 5. Individual #376 (8/14/09) 6. Individual #586 (11/27/07) 7. Individual #294 (6/16/09) 8. Individual #447 (6/13/13 and 5/27/14) 9. Individual #507 (9/9/08) 10. Individual #535 (9/10/13) 11. Individual #192 (7/15/14) 12. Individual #33 (8/27/13)	

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		Speech Language/Communication Assessment of Current Status 1. Individual #267 (3/18/14) 2. Individual #220 (3/18/14) Other Communication Assessments, Screenings, or Updates 1. Individual #203 (10/27/03, 11/3/00, and 3/23/92) 2. Individual #227 (8/9/13) 3. Individual #313 (5/20/08) • 14 of 26 individuals (54%) in Samples R.1 and R.4, were provided an assessment or update current within the last 12 months. No assessments were submitted for Individual #513, Individual #368, Individual #467, Individual #108, Individual #546, or Individual #238. Three individuals were listed with AAC, yet only two of those (67%) had a current assessment (Individual #447 and Individual #241). Four had PBSPs and significant communication deficits, yet only two of these (50%) had current assessments (Individual #447 and Individual #294). Individual #185 participated in direct speech therapy per his assessment dated 7/30/13. There was no evidence that an update had been completed. Twelve of the 16 individuals in Sample R.1 were listed as a Priority 1 or 2, likely with significant communication needs, yet only three of these had been provided a current assessment (25%). Communication needs for these individuals were not known because they had not been provided a communication assessment in the last five or more years (and none of those would be adequately comprehensive to accurately identify individuals' needs). This was also true of three of the four individuals listed as Priority 3 (Individual #513, Individual #203, Individual #185, and Individual #238) because only Individual #185 had been provided a current assessment. • 4 of 5 individuals admitted since the last review (80%) received a communication assessment/screening within 30 days of admission. By report, they were screened to determine their priority level and placed on the Master Plan. Each was identified as Priority 4. It was noted in the case of Individual #220, that he was screened after his admission to LSSLC. Communication supports were recommended at that time. In that case, the clinician should have discontinued the screening and immediately initiated a comprehensive assessment. Instead, he was placed on the Master Plan as Priority 1. While a comprehensive assessment was completed a year later, this should have been done at the time of his admission. This was also noted related to Individual #20. Since the current year admission screenings were not submitted, it could not be determined whether any supports were indicated. It was not clear that the facility had a formal screening tool for use with individuals who were newly admitted to the facility to identify their current communication status and to	

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		determine if further assessment was needed to clearly outline needs for supports and services because nothing was submitted for that request. They were encouraged to develop a strong tool for this purpose to ensure that the process was consistent across therapists. This could also be used for other individuals identified as Priority 4 to determine if a comprehensive assessment was indicated. In the case that this was not needed, the clinician should indicate on the screening tool that the individual had functional communication skills and that further assessment was not required, unless there was a change in status or per IDT request. This document should be placed in the active record and not purged unless, or until, another screening or assessment was completed in the future. For 12 of 26 individuals (46%) in Samples R.1 and R.4, the assessments or updates were dated as having been completed at least 10 working days prior to the annual ISP. No current assessments were submitted for 12 individuals. Per the self-assessment, there were 37 individuals who required assessment for their annual ISPs, though only 24 of these were completed. Timely submission was reported to be 83% for assessments completed during that period. The tracking log listed 119 individuals with ISPs between 4/1/14 and 7/31/14. Only 37 were completed, with 86% of those on time. The log and Master Plan documentation were no consistent and the calculations in the log did not appear to be accurate and should be reviewed. As stated above, there were 224 individuals who were identified as Priority 1 and 2 (i.e., those who presented with communication deficits), yet only 32 were listed with current assessments (14%). • The following metric was not applied because LSSLC did not submit communication screenings at the time of this review, so this could not be determined. For --% of individuals identified with communication needs through a screening, a comprehensive communication assessment was completed within 30 days of identification. Based on review of the assessments submitted and included in Samples R.1 and R.4 (16 individuals), there were seven individuals with comprehensive assessments completed within the last 12 months: Individual #241 10/1/13), Individual #90 (4/23/14), Individual #185 (7/30/13), Individual #410 (12/13/13), Individual #182 (11/13/13), Individual #20 (10/22/13), and Individual #294 (4/28/14). Only five had been completed since the implementation of the most current format implemented in October 2013 (Individual #241, Individual #410, Individual #182, Individual #20, and Individual #294). As such, the other assessments completed were not included for review. Five current assessments for each clinician were requested for review R.2. Five were submitted for Chris Pedroni and Kristi Hodges, and six were submitted for Maegan Melton. All but four were a comprehensive assessment and the assessment for	

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		Individual #294 was duplicated in Sample R.1. Thus, there were a total of 17 comprehensive assessments included in the review below. 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 comprehensive communication assessments was as follows: • 13 of 17 assessments (76%) were signed and dated by the clinician upon completion of the written report. This was a decrease from 100% in the previous review. • 15 of 17 assessments (88%) included diagnoses and relevance of impact on communication. This was a decrease from 100% in the previous review. • 17 of 17 assessments (100%) included individual preferences and strengths. Ideas for how to integrate preferences into communication opportunities was not generally identified in these assessments. This was consistent with the previous review. • 15 of 17 assessments (88%) included medical history and relevance to communication. This was a decrease from 100% in the previous review. • 12 of 17 assessments (71%) listed medications and discussed side effects relevant to communication. This was an increase from 67% in the previous review. • 11 of 17 assessments (65%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was an improvement from 33%. In many cases, the risks were not listed, but rather dismissed as irrelevant to communication. In a few cases, however, the clinician indicated that the individual's ability to report pain or discomfort was a concern relative to specific risk areas. In some cases that behavior challenges were identified, there was no reference to communication in relation to this in the risk discussion. • 16 of 17 assessments (94%) 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 a decrease from 100% in the previous review. • 15 of 17 assessments (88%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was an improvement from 67% in the previous review. • 13 of 15 assessments (87%) 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 changes as required. There was no discussion of specific changes that were indicated or recommended, but rather only that the team should review the dictionary. In many cases, this was not included as a recommendation and, as such, may be missed during the assessment review. This was a decrease from 100% in the previous review.	

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		• 17 of 17 individuals' communication assessments (100%) included discussion of the expansion of the individuals' current abilities. This was consistent with the previous review. • 15 of 17 individuals' communication assessments (88%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 67% in the previous review. • 4 of 17 assessments (24%) included the effectiveness of current supports, including monitoring findings. This was an improvement from 0% in the previous review. This section referred only to the review of supports and services during the assessment in many cases, rather than monitoring conducted by the clinician and/or PNMPCs throughout the year. • 14 of 17 assessments (82%) assessed AAC needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC. This was an improvement from 67% in the previous review. In a number of assessments, the judgment for AAC was based on the assessment process only rather than attempts to use AAC in a meaningful context during the routine of the individual's day. It was not clear if the individual was not interested due to the lack of meaning, lack of use of preferred items, etc. In other cases, the AAC assessments appeared to be thorough and appropriate. • 16 of 17 assessments (94%) offered a comparative analysis of health and functional status from the previous year. Two of these were for individuals who were newly admitted so this information was limited. This was a decrease from 100% in the previous review. • 17 of 17 assessments (100%) gave a comparative analysis of current communication function with previous assessments. This was consistent with the previous review. • 17 of 17 assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was consistent with the previous review. • 9 of 17 assessments (53%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was a decrease from 100% in the previous review. The strategies were limited to guiding staff to understand the individual, but strategies for staff to use to communicate effectively with the individual were not identified. If any strategies are deemed to be unnecessary, this should be stated with a rationale. • 17 of 17 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 14 of 17 assessments (82%) supplied a monitoring schedule. This was a decrease from 100% in the previous review. • 9 of 17 assessments (53%) had recommendations for direct interventions	

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		and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was a decrease from 100% in the previous review. • 15 of 17 assessments (88%) made a recommendation about community referral and transition. This was a decrease from 100% in the previous review. • 7 of 17 assessments (41%) included specific recommendations for services and supports in the community. This was an increase from 33% in the previous review. This was generally omitted or was too general and insufficient for placement planning, such as the need for a speech therapist or the need for a communication dictionary. • 14 of 17 assessments (82%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was a decrease from 100% in the previous review. Again, there was little offered as to how staff should communicate with the individual. Additional findings related to the communication assessments were as follows: • Five of 23 elements were noted in 100% of the assessments reviewed. • Eight of 23 elements were noted in 90% or more of the assessments reviewed. • 2 of 13 assessments (15%) contained 100% of the 23 elements listed above. Previously, none had 100%. • 5 of 12 assessments (42%) contained 90% or more of the essential elements listed. • Eight assessments contained less than 80% of the elements. • The average for all 17 assessments was 80%. • There was a decrease across 12 elements. Improvements were noted for six elements, while the others remained consistent with the previous review at 100%. It was reported that self-audits were conducted with findings consistently at or near 100% compliance. This was significantly different from the above findings by the monitoring team. By report, inter-rater reliability for the self-audits was not yet developed, but planned for the near future. It should be noted that some assessments were very strong and others were significantly weaker. There was also a considerable difference in the formats used across therapists. It was the monitoring team's understanding that there was to be standardization of format for all discipline assessments per the state office, but this was not in consistent use across the 13 assessments reviewed. The facility should review these guidelines and ensure they are appropriately integrated into the standard format to be used by all speech clinicians. Only one current Assessment of Current Status (ACS) was submitted, for Individual #447 included in Sample R.1. The others submitted were part of Sample R.2 and R.4	

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		(Individual #220, Individual #406, Individual #267, and Individual #500), though these were not included in the following metric because they were submitted as assessments only, without the associated comprehensive assessments. • 1 of 1 update (100%) was completed consistent with the established schedule, the individual's need, and/or previous recommendations, and the associated comprehensive assessment was present in the individual record (Individual #447). Each of the Assessments of Current Status (the most current format for annual updates) submitted included the following minimum requirements: • The individual's current status • Description of the interventions that were provided • Effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year • Monitoring and re-assessment schedules. <u>SLP and Behavioral Health Collaboration:</u> There were approximately 151 individuals identified with behavioral issues and co-existing severe nonverbal or limited verbal skills. There were 88 individuals listed with PBSPs who also had replacement behaviors related to communication. At least eight individuals in Sample R.1 were listed with a PBSP and each was submitted in their individual record. Six of these were current. The others were not current within the last 12 months (Individual #294 and Individual #513). Only two of these had current communication assessments (Individual #447 and Individual #294). Based on review of the current plans and communication assessments, the following was noted: • For 1 of 8 communication assessments (13%) in Sample R.1 for individuals with identified challenging behaviors, there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section (Individual #294). This was a decrease from 44% in the previous review. The discussion in Individual #447's assessment was limited to naming the target behaviors and noting that these had not been seen during therapy. • 0 of 8 communication assessments and PBSPs reviewed (0%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. As stated above, only two individuals had current communication assessments. Individual #294's PBSP was not current within the last 12 months (6/15/13) and at the time it was developed there was no current communication assessment. The PBSP indicated, however, that Individual #294 was learning to use a communication wheel. The assessment dated 4/28/14 (approximately a year later than the PBSP) indicated that this was used	

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		effectively by staff to communicate with her, rather than her using it to communicate. The PBSP stated that staff should encourage her to use the communication wheel if she begins banging her head. The wheel was identified as a "fidget" for her in the communication assessment. Individual #447's assessment did not address the PBSP. His PBSP stated that he understood American Sign Language (ASL) and that it should be considered his best and primary language, though it was also stated that he used a communication board. His communication assessment indicated that he understood basic questions, but not abstract ones. It specifically stated that he communicated best using pictures and voice output devices. It was reported that he used only limited ASL. These discrepancies were of concern. • 1 of 8 communication assessments (13%) contained evidence of review of the PBSP by the SLP. • For 1 of 8 individual (13%), communication strategies identified in the assessment were included in the PBSP. A plan should be developed to ensure that the communication strategies outlined in the communication assessment would be attached to all PBSPs. Of course, this would be dependent on the availability of a current communication assessment and PBSP. • For 1 of 8 individuals (13%), communication strategies related to behavior identified in the assessment were included in the ISP (Individual #447). The behavioral health section indicated that replacement behaviors involved the use of a communication lap-board which was generally consistent with his most current communication assessment. The relationship between communication and behavior was not clear per the ISP for Individual #294. The target behavior did not appear to be communication–based, yet she was listed with a communication-related replacement behavior and Individual #447 was not, per the list submitted (XV.17). Minutes for meetings held to review PBSPs during the last six months were reviewed. • Based on review of the Behavior Support Committee meeting sign-in sheets from 1/7/14 through 5/13/14, participation by a SLP or SLPA was noted in 2 of 18 meetings (11%). A spreadsheet submitted in the Section R Presentation Book, identified that a SLP was present at 11 of 12 (92%) of the Behavior Support Committee meetings. The reason for this discrepancy in documentation was not clear. Participation in the review of PBSPs during these meetings was one opportunity for collaboration between behavioral health and speech staff. There should be an effort to develop collaborative replacement behavior goals related to communication and to ensure that communication strategies were consistent. By report, this was often not	

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		possible at the BSC meetings because the PBSPs were finalized prior to their review. It is understood that collaboration for assessment and development of PBSPs and communication plans may need to occur prior to the time of review by the Behavior Support Committee and, in that case, the facility is encouraged to document those efforts. There may be other means to accomplish this beyond the PBSP meetings, particularly during the pre-ISP planning and during the assessment process. The communication assessments did not consistently report communication and behavioral health issues related to the interpretation of the functions of target behaviors and whether there was a communication component. Evidence of additional efforts should be documented and evident in the supports and services developed. The facility self-rated this provision not in substantial compliance, and the monitoring team concurred based on the findings reported above. Further coaching and monitoring of speech clinicians will be necessary to maintain compliance with the essential elements for communication assessments. Weaknesses, particularly related to AAC assessment should be addressed for some clinicians.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP:</u> Attendance at the annual ISPs for individuals was reviewed. The ISP submitted for Individual #192 (7/10/13) was not current within the last 12 months. There was no sign-in sheet per the ISP submitted for Individual #410. Pre-ISP required attendance sheets were submitted only for Individual #203, Individual #376, and Individual #507. • For 9 of 25 individuals in Samples R.1 and R.4 (36%), a SLP (or SLPA in two cases) was in attendance at the ISP. A SLP was not designated to attend per the pre-ISP in three cases. Communication supports had been recommended for most of these individuals indicating a need for SLP participation in their ISPs. • For 4 of 25 individuals (16%), communication strategies identified in the assessment were included in the ISP. A number of these referenced communication assessments that were four to five years old because a more current one was not available. • In 10 of 25 ISPs for individuals with communication supports (40%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, and strategies for staff use) were identified. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for only 16%%, as evidenced in the ISP. Some only mentioned the dictionary as a support, but did not reflect IDT review. • 25 of 25 ISPs (100%) included a description of how the individual communicated, though some provided a very limited description, and most were not guided by a current communication assessment. • 3 of 25 ISPs (12%) contained skill acquisition programs to promote	Noncompliance

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		communication. Some identified the need for SAPs, but these were not translated to the ISP action steps. One SAP merely identified that the individual would be enrolled in speech, but without stated objectives in the ISP. Others identified outcomes that were for staff rather than objectives that would result in measured skill acquisition for the individual. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was not consistently addressed in the ISPs reviewed, other than in the assessment inserted into the beginning of the ISP. One exception was Individual #294. There was limited evidence that the IDT discussed communication. This appeared due to the absence of current communication assessments and that SLPs did not often attend the ISP meetings. Few ISPs outlined that the dictionary was reviewed and that modifications were or were not required. Most had a brief summary of how the individual communicated, but had little as to how staff should communicate with them. The communication strategies outlined in the communication assessments were limited. The clinicians should clearly outline individualized communication strategies for staff to use with each individual that best complements how they communicate and understand others, and/or can enhance the effectiveness of their communicative efforts. Consistent integration of these by listing them into the ISP would be a useful practice. <u>Individual-Specific AAC Systems:</u> There were approximately 217 individuals living at LSSLC who presented with significant communication deficits. By report, only 50, or 23%, of these had been provided an AAC device and/or a SAP to address their communication deficit. Only some of these had a current assessment and many others had yet to be evaluated. The systems were generally portable, functional, and individualized. Individualized AAC device instructions were developed in most cases to provide a picture of the device and to clearly outline the purpose with staff instructions for use and care of the device. There were 55 individuals listed as participating in direct communication therapy intervention at the time of this review and/or during the last six months. Communication dictionaries (CD) were also provided to many individuals, though the extent was not known to the monitoring team. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This should enhance staff understanding of the individual and promote consistent responses, but does not specifically improve the individual's expressive or receptive skills. Changes needed to the CDs were not specifically outlined in the ISP. In some cases, review and changes were stated as needed, but not specifically outlined, even in the communication assessments.	

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		The following metric could not be determined: • --% of individuals for whom the IDT directed a revision in the communication dictionary, the communication dictionary was revised within 30 days. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings, such as to request a favorite item, food, beverage, music, vibration, or massage. In some cases, the assessments reported that a device was tried with an individual, but when they did not spontaneously use it, the device was dismissed as a viable option. Specific efforts to promote practice and use in the natural environment should be identified for those individuals. This has been noted by the monitoring team in previous reviews. <u>General Use AAC Devices:</u> There were a number of general use devices noted in many homes. All of the systems noted during this onsite review were operational, and had a clear function within the environment, though none were seen in use. Directions were not necessarily posted, though use of these was competency-trained in NEO. <u>Direct Communication Interventions:</u> There were approximately 55 individuals listed as participating in direct communication-related interventions provided by the SLP. Records related to the provision of direct intervention for a sample of these individuals were reviewed (nine individuals randomly selected from Sample R.4). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • For 3 of 9 individuals (33%), 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 9 of 9 individuals (100%), the current SLP assessment identified the need for direct intervention with rationale. • For 1 of 9 individuals (11%), there were measurable objectives related to individual functional communication outcomes included in the ISP/ISPA. Most merely indicated that the individual would participate in therapy with no specific goals stated. • For 2 of 9 individuals (22%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). Documentation revealed poor implementation in many cases and notes written were generally anecdotal rather than data based.	

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		• For 0 of 9 individuals (0%), there was a description of the benefit of the device and/or goal to the individual in the progress notes and/or monthly summaries. This was generally outlined in the assessments, however. • For 2 of 9 individuals (22%), consistency of implementation was documented. Days on which therapy was not provided were clearly documented, however, the consistency of implementation for most interventions was extremely poor. Reasonable progress could not be expected when the majority of sessions were not conducted. Even though 55 individuals were receiving direct therapy, most did not participate regularly or the therapist was not routinely available. • For 0 of 9 individuals (0%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. There was minimal evidence of monthly review by any clinician to determine whether progress had been made and that recommendations for changes to the plans were indicated. • For --% of individuals for whom direct intervention had been discontinued (NA), termination of the intervention was well justified and clearly documented in a timely manner. Each of the nine individuals reviewed were documented as still enrolled in direct therapy, though a number of these were not actually implemented. Five others who were discharged and for whom documentation was submitted as requested are discussed below. • 0 of 9 individuals (0%) individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the generally accepted 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. o Completed at least monthly. Data collection was addressed for each session. A monthly notation summarized overall progress for the month. There were session notes routinely written and they stated whether therapy had occurred on a specific day, but there was very limited evidence of review at least on a monthly basis to address each of the elements above. Some additional concerns included the following: • Individual #20's ISP (9/3/13) indicated that she needed a communication	

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		assessment and that she and her staff needed an effective manner to communicate. An action referral was sent and the reply indicated that Individual #20 had been participating in direct therapy with the SLP since July 2012 (over one year) to address intelligibility issues. It was of concern that the IDT was not made aware of this and after mort than a year in therapy, the IDT believed that Individual #20 and her staff needed effective communication strategies. On 10/22/14, an ISPA was held to discuss the findings of the communication assessment. The SLP recommended that she continue in direct therapy for 120 days (through February 2014), but no specific strategies were outlined. Due to inconsistency of the interventions and the lack of clinical data, actual progress was not clear. It was noted that Individual #20 continued to be enrolled in direct therapy as of 6/30/14 with no clear rationale for continuation at least four months beyond the initial plan. • Direct therapy for Individual #220 began a month prior to his annual ISP, but no ISPA was held to integrate this into his current ISP. • There were several individuals for who repeated progress note sheets were filed, but without any documentation as little or no therapy had been conducted (Individual #410, Individual #33, and Individual #535). • Individual #267 participated in AAC trials since 4/1/13, but there was no evidence of documentation until 9/3/13. • The discharge process from direct intervention was weak and inconsistent across clinicians. The following individuals were reported as discharged from therapy in the last six months and documentation was reviewed: o Individual #598: Her intervention plans indicated that she was to participate in direct therapy four to six times per month. Review of the attendance records revealed that she was seen an average of less than two times per month from September 2013 through March 2014. There was no discharge summary that identified the goals, summarized the course of intervention, her progress, and a rationale for discharge. An ISPA written by the SLP dated 3/14/14, stated that she was being dismissed from therapy due to a lack of progress and indicated that she was indifferent to therapy. Absences by the individual and clinicians, including holidays were clearly documented, but it did not appear that there were attempts to reschedule missed sessions. o Individual #128: There was no evidence of her participating in direct therapy and no evidence of discharge. o Individual #294: Her intervention plan indicated that she was to participate in direct communication intervention two to three times per month. Review of the attendance records indicated that she was seen an average of less than two times per month from August 2013 through	

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		January 2014. There was no discharge summary. An ISPA written by the SLP, dated 1/29/14, stated that she was being dismissed from therapy with no rationale given. Absences by the individual and clinicians, including holidays, were clearly documented, but it did not appear that there were attempts to reschedule missed sessions. o Individual #418: His intervention plan indicated that he was to participate in direct communication intervention four times per month. Review of the attendance records indicated that he was seen an average of only two times per month from February 2014 through May 2014. There was a discharge summary by the clinician that identified the goals, summarized the course of intervention, his progress and a rationale for discharge. There was no evidence of an ISPA, however. Absences by the individual and clinicians were clearly documented, but it did not appear that there were attempts to reschedule sessions. o Individual #337: His intervention plan indicated that he was to participate in direct communication intervention three to four times per month. Review of the attendance records indicated that he was seen an average of 3.5 times per month from October 2013 through March 2014. There was no evidence of a discharge summary. An ISPA, written by the SLP, stated that he would be discharged from therapy until an assessment was written. The documentation described did not meet the standards of generally accepted professional standard of care. Therapy was often recommended, but there did not appear to be a focus on the provision of these interventions. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication plans, communication dictionaries, general use AAC, and communication-related SAPs. AAC supports were identified in the annual assessment and described in the PNMP and, in some cases, individual communication plans, including pictures of specific devices as indicated in conjunction with the PNMP. Other indirect supports should be developed in the form of SAPs implemented by DSPs in the home, day program, or work areas. There were a significant number of SAPs developed for replacement behaviors, though SLP involvement in the development of these and routine monitoring was not apparent. SLPs are also encouraged to work closely with the program developers on new or existing SAPs (not only those related to communication) to ensure that communication strategies are well integrated into these plans. The challenge moving forward is ensuring that these plans are implemented as intended and this requires real-time modeling and coaching.	

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		Documentation for individuals who received indirect communication supports (SAPs) should include the following elements: • Implementation within 30 days of the plan's creation (typically as of the ISP or ISPA), or sooner as required by the individual's health or safety. • The current SLP assessment should clearly identify the need for indirect intervention with rationale. This was consistently noted for the assessments completed and reviewed. • Measurable objectives related to individual functional communication outcomes to be achieved through indirect intervention should be in the ISP. • Staff instructions provided for individuals' AAC devices, including written step-by-step instructions and pictures. <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. Based on the schedule submitted, class time to address communication was not outlined. At the time of this review, there was no refresher class related to communication. Communication is an issue shared by all individuals and a key element to the successful provision of all supports provided by staff. As such, significant time is needed to provide instruction for new employees, as well as for existing staff. Based on the information from the previous review, Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Class time included four hours for communication and AAC. New content was implemented as of December 2013. 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 any	

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		time the employee could be required to repeat the class. The training materials should address the minimum foundational content areas 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 • 99% of the 138 new employees required to attend communication training from 1/1/14 through 6/30/14 completed NEO core foundational skill training and passed performance check-offs based on the participation reports and self-assessment. • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. There was no refresher training developed and implemented in the area of communication/AAC. As such, the following metrics were not applied: • % of staff required to take the Annual Refresher class related to communication successfully passed the competency check-offs. • There was/was not a system to establish and maintain competency for staff who provided the training. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was to be provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO training curriculum. This type of training required competency check-offs in order that staff could implement that element. There were no individuals identified with non-foundational components related to communication at the time of this review. The facility had established a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. At this time, training on an individual basis was not conducted because no one required any specialized techniques that were not already taught in NEO. This further emphasized the need for a refresher course related to communication to ensure that existing staff maintained competency in the implementation of new and/or existing communication systems and strategies for the individuals to whom they were assigned.	

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		The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though improvements continued, there was insufficient integration of communication supports and services into the ISP and inconsistencies related to the provision and documentation of direct therapy. 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 the information in the communication assessment related to the PBSP was well integrated. Ensure that the communication strategies are effectively translated into the PBSP and consistent with the individual's communication function and methods of communication. 2. Ensure that information related to communication was effectively translated to the ISP. 3. Address the consistency and necessary elements of documentation of direct interventions. 4. Develop and implement annual refresher training in the area of communication for existing employees	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Compliance Monitoring of Implementation of Communication Supports</u> A system of compliance monitoring was established at LSSLC since the previous review using the Communication/Compliance Monitoring Tool. This form addressed the following: • Equipment was available. • Equipment was in good condition. • Implementation as per the plan. • When equipment was used, staff responded. • Staff accurately described or demonstrated how the device or objective should be implemented. The following were implied, but not directly addressed: • Plan was current and available. • When equipment was used, staff responded. Completed forms for communication-related compliance monitoring conducted in the last month were requested (CC.15) for the individuals in Sample R.1 with communication supports (17 individuals). No forms were submitted for review. Also, monitoring forms	Noncompliance

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		completed in the last month were requested (XV.12). At least 39 forms for 23 individuals, including 10 for four individuals from sample R.1 (Individual #174, Individual #267, Individual #241, and Individual #294) were submitted. Upon review of the forms submitted, the following was noted: • 77% of the completed forms merely checked that the equipment was available and working, but did not observe whether the communication system was implemented as intended (staff drills were marked "NA"). • A compliance score was recorded on 10 forms, though at least five of these were marked 100% compliance even though there was no indication that observation of staff implementation of the system. • In the case of Individual #375 (6/4/14), the device was not available and the indicator related to whether it was clean and in good repair was marked "NA." A note attached indicated that the tray had been torn off the mounting device. The PNMPC indicated that staff had not reported that an item was in disrepair, but this also was not reflected accurately on the form. The compliance score was inaccurately recorded as 66%. • In the case of Individual #502 (6/6/14), there were three indicators marked as a "no," including that the device was broken, yet the indicator that staff demonstrated how to use the system was marked as "yes" and the compliance score was calculated to be 80% rather than 70%. • On a positive note, the form completed for Individual #502 directed the PNMPC to monitor again in one week and this was documented on 6/13/14. Compliance monitoring should be conducted routinely to address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities. This may be also accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. The intended frequency of compliance monitoring was not clear and did not include all individuals who were provided a communication system. All equipment should be monitored routinely (at least monthly) for availability, condition, and working order with routine general check-offs that the systems were implemented as intended. Communication dictionaries should be monitored for availability, effectiveness, and whether staff understand how to use them. This did not appear to be done. <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	

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		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. This should address any changes in risk or health and functional status of the individual since the previous review, staff compliance, as well as, whether the supports and/or strategies effectively met the intended need. Frequency of these should be included in the ISP with documentation of findings in the individual record (IPNs). Documentation 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, consistency of implementation • 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 LSSLC, there was no specific tool used to address effectiveness monitoring. At least 14 individuals were listed as seen in the monthly communication clinic, though the documentation for this clinic did not address the elements listed above. Though equipment was checked at this time, a determination that all of the communication supports provided to each individual were appropriate, consistently and accurately implemented, and meeting the identified needs was not done. There were at least another 41 individuals listed with AAC, and others with communication supports, that were not reviewed on at least a quarterly basis. This occurred only annually in the case that an annual assessment or update was completed. The facility concluded that they were not in compliance with this provision of section R, and the monitoring team concurred as described above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Review the consistency and accuracy of communication monitoring. 2. Many of the assessments reviewed recommended monthly monitoring, but did not necessarily distinguish between compliance monitoring and effectiveness monitoring and this should be clearly established. 3. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines to enhance consistency. Consider use of an IPN to further document these findings.	

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		4. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment or other established guidelines. Ensure that these findings are included in annual communication assessments for individuals.	

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 #551, Individual #470, Individual #402, Individual #526, Individual #128, Individual #116, Individual #344, Individual #55, Individual #85, Individual #20, Individual #228, Individual #279, Individual #265, Individual #194 o Skill Acquisition Plans (SAPs) for: • Individual #551, Individual #470, Individual #402, Individual #526, Individual #128, Individual #39, Individual #368, Individual #91, Individual #27, Individual #313, Individual #59, Individual #367, Individual #560, Individual #178 o Monthly review of SAP progress for: • Individual #551, Individual #470, Individual #402, Individual #526, Individual #128 o Functional Skills Assessment (FSA) for: • Individual #551, Individual #470, Individual #402, Individual #526, Individual #128 o Personal Focus Assessment (PFA) for: • Individual #551, Individual #470, Individual #402, Individual #526, Individual #128 o Vocational assessments for: • Individual #551, Individual #470, Individual #402, Individual #526, Individual #128 o Training materials used to teach staff to implement skill acquisition plans, undated o Sections F & S Presentation Book, undated o Section S Action Plans, 6/9/14 o Section S Self-Assessment, 6/24/14 o SAP integrity form, undated o SAP integrity checks for February, March, and April 2014 o SAP peer review data for 1/14-4/14 o Active treatment rating form, undated o Active treatment goals and totals per home for 2/14, 3/14, and 4/14 o Percentage of functional skills assessments, preference and skills inventories, and vocational assessments, submitted at least 10 days prior to the ISP for January 2014-June 2014 o Listing of on and off campus day and work sites, 5/1/14 o List of individuals employed on and off campus, undated o Summary of community outings, January 2014-April 2014 o Summary of community SAPs developed across units for March 2014 –June 2014 o List of students, showing all students who started the school year in September 2013 and all enrollment changes since then (e.g., graduations, discharges, admissions) o ISPs, ARD/IEPs, ISD progress notes, and LSSLC ISPAs for

	• Individual #116, Individual #344, Individual #55 Interviews and Meetings Held: o Stephani Sowell, QIII; Robin McKnight, BCBA, Director of Behavioral Health; Mary Gill, Q-assistant; Linda Grimes, Q Compliance Monitor; Suzanne McWhorter, Behavior Health Specialist o Myra Washington, ATC; Vickie Laird, ATC o Todd Miller, Residential Services Manager; Mary Stovall, Oak Hill Unit Director; Kenneth Self, Woodland Crossing Unit Director; Julie Olivares, Lone Pines Unit Director o Stephani Sowell, QIII, and Mary Gill, administrative assistant, regarding public school Observations Conducted: o Pre-ISP meeting for: • Individual #116 o SAP peer review meeting o Pretreatment Sedation Committee meeting o SAP implementation for: • Individual #560, Individual #178 o SAP integrity session for: • Individual #178 o Observations occurred in various day programs and residences at LSSLC. These 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 did review some of the items contained in the monitoring team's report, such as if functional skills assessments and preference and strengths inventories were completed prior to the ISP. The focus of S2 in the monitoring team's report, however, is on determining if assessments were clearly used to select individual skill acquisition plans, and this topic was not addressed 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 resulting in the staff responsible for writing skill acquisition plans (SAPs) being moved to the behavioral health services department (S1) • Overall improvement in the quality of SAPs (S1) • Continuous progress in pretreatment sedation reduction (S1) • Establishment of individual engagement goals (S1) • Increase in the percentage of SAPs that are documented to be based on assessment results (S2) • Improvements in the documentation of assessments completed prior to the ISP (S2) • Improvements in the SAP integrity tool (S3) • Expansion of SAP integrity (S3) • Establishment of a data system to track the implementation of SAPs in the community (S3) The monitoring team suggest that the facility focus on the following over the next six months: • Ensure that SAP training instructions following an incorrect response are clear and tailored to individual needs (S1) • Ensure that goal prompt levels are included in all SAPs (S1) • Ensure that all SAPs focus on learning new skills (S1) • Expand the number of communication SAPs for individuals with communication needs (S1) • Demonstrate that established day and residential individual engagement goals are achieved (S1) • Ensure that at least 85% of functional skills assessments and preference and strengths inventories 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 SAP data are consistently graphed and used to make data based decisions concerning their continuation, discontinuation, or modification (S3) • Ensure that goal frequencies and levels of SAP integrity are achieved (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). At the time of the onsite review, four program developers wrote the majority of SAPs. Since the last review, the program developers were moved to the behavioral health services department. SAPs continued to be implemented by direct support professionals (DSPs), who 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. The monitoring team reviewed a total of 26 SAPs across 14 individuals. In 25 of the 26 SAPs reviewed (96%), the rationale appeared to be based on a clear need and/or preference. This represented an improvement from the last review when 86% of the SAPs appeared practical and functional. 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	Noncompliance

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		• Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology All of the SAPs reviewed contained all of the above components. Additionally, the quality of some of these components was improved. For example, 24 of the 26 SAPs reviewed (96%) included a complete plan for generalization. This was another improvement over the last report when 79% of generalization plans were judged to be complete. While a generalization plan describes how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation, a maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of formal training. Twenty-three of the 26 SAPs reviewed (88%) included a plan for maintenance that was consistent with the definition above. This was a decrease from the last review when 100% of the maintenance plans were judged to be consistent with the definition above. An example of a complete maintenance plan was: • The plan for maintenance in Individual #402's SAP of activating a voice output box indicated that once he mastered this SAP he would be encouraged to use the box to communicate, and DSP's would be instructed to continue to respond to his use of the box. An example of unacceptable plan for maintenance was: • The plan for generalization for Individual #470's SAP of grasping objects stated she will be able to grasp other items. This better represents a generalization plan rather a maintenance plan. A maintenance plan consistent with the above definition might include, once she successfully completed this SAP, Individual #470 will continue to be encouraged to grasp desired items. One common shortcoming of the SAPs reviewed was unclear training instructions following an incorrect response. The majority of SAPs reviewed indicated that a least to most prompting sequence should be used following a refusal or incorrect response.	

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		Including the specific training prompts is important because it is likely that some prompts with some individuals (e.g., hand-over-hand guidance) could lead to behavioral issues that would interfere with learning. Additionally, "taking a break" following a refusal may be the most effective training strategy with some individuals. As discussed in more detail in S3, it is recommended that specific and individualized training instructions be included in all SAPs following a refusal or incorrect response. Although all of the SAPs reviewed contained behavioral objectives, some were judged to be unclear because they did not include the goal prompt level. The majority of SAPs reviewed included the goal prompt level in a section on the SAP referred to as Criteria for Success. Four of the SAPs reviewed (15%), however, did not appear to contain the goal prompt level in either the behavioral objective or the criteria for success sections (e.g., Individual #470's SAP to learn to apply lotion). Finally, two of the 26 SAPs reviewed (8%) consisted of SAPs to NOT engage in a behavior. For example, Individual #91 had a SAP to not slam doors. Skill acquisition plans represent new behaviors that are learned. These new skills often are intended to teach an individual new (i.e., more desired, less dangerous, less disruptive) ways to have access to the things people desire. It is recommended that all SAPs focus on teaching new skills (e.g., safely closing doors), rather than attempting to teach the absence of a behavior. The facility continued to use a combination of training methodologies (e.g., shaping, forward chaining) to train SAPs. <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 were 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	

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		plans/strategies. At this point, LSSLC appeared 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> Two of the 14 individuals reviewed (14%) had a skill acquisition program targeting the enhancement or establishment of communication and language skills. This was an improvement over the last review when only 6% of the individuals reviewed had SAPs that targeted the enhancement or establishment of communication and language skills. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs (also see section R). <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at LSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals 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 a wide range of individual engagement across the residential units. For example, home 563A appeared to have consistently high engagement among individuals, while home 524 had poor individual engagement on one day, and very good engagement the following day. 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 57%, a decrease from the last review when engagement was 66%. LSSLC staff continued to conduct their own individual engagement. Active treatment	

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		coordinators (ATCs) were required to do at least one observation per shift. Since the last review, the observation was modified to a momentary time sample (similar to what the monitoring team used to measure individual engagement), and they established individualized engagement goals across all treatment sites. April 2014 engagement data indicated that engagement averaged 81% across all treatment sites, and that engagement goals were achieved in 16 of 21 (76%) treatment sites. One reason discussed for the substantially better facility engagement scores compared to the monitoring teams scores was that the ATCs conducted engagement measures on their own homes. The facility indicated that they would begin to have ATCs conduct engagement measures on treatment sites that they did not work. At this point, it is recommended that the facility ensure that engagement targets for day program and residential treatment sites are achieved. Engagement Observations: Location Engaged Staff-to-individual ratio 549B 3/4 3:4 549B 1/4 0:4 549C 1/3 1:3 549D 2/5 2:5 524 1/7 1:7 524 1/5 1:5 524 1/4 1:4 563A 4/5 3:5 563B 2/2 1:2 563B 2/3 1:3 520 2/2 2:2 561A 2/3 1:3 563A 2/2 1:2 561A 1/2 1:2 561A 1/6 1:6 561B 1/2 1:2 524 6/6 1:6 524 7/8 2:8 506 3/6 2:6 557A 1/8 1:8 557A 3/4 1:4 557B 5/9 1:9 559A 4/12 2:12 559B 3/7 2:7	

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Small Workshop	12/12	4:12
509	3/3	3:3
510 Building	2/10	2:10
550 Building	2/8	2:8
550 Building	2/8	2:8
560 Building	2/2	2:2
Oak Hill day prog.	2/3	1:3
560 Building	2/5	1:5
560 Building	3/4	1:4

Educational Services

Twenty-four individuals at LSSLC qualified for educational services from the local ISDs since the last review. As described in previous reports, most LSSLC students now attended Central ISD rather than Lufkin ISD.

The working relationship between Central ISD and LSSLC was described by LSSLC staff as remaining extremely positive, and that this past school year was very good for the students and staff. LSSLC staff reported that there was a lot of contact between Central ISD teachers and special education staff, including visits to the school program by LSSLC QIDPs, behavioral health specialists, and others. LSSLC staff attended ARD/IEP meetings regularly and signed attendance sheets for those meetings. Similarly, Central ISD staff visited the LSSLC campus and occasionally attended meetings.

Of the 24 students, 10 attended school at Central ISD schools and 8 attended the CISD classroom at the LSSLC campus (one had since transferred to another SSLC). The other 6 students remained at Lufkin High School where they were going to finish out their educational program (one of these six graduated this past year and one transitioned to the community).

At CISD, the students attended full day, with few returns. Data on returns no longer needed to be maintained because it was no longer a problem. Also, a new teacher was hired by CISD for the LSSLC classroom for the upcoming school year. This will likely result in improved attendance, participation, and curriculum content; problems in the LSSLC classroom that were noted in previous reports.

The monitoring team also looked to see if educational programming was appropriately incorporated into the ISP. The school placement was described in the ISP, but there was little incorporation of educational activities into action plans and SAPs. During the last review, this was discussed with the facility staff. The ISPs submitted for this review of educational services were from 2013, that is, prior to the last review. Thus, examples of

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		any improvements since the last review were not presented to the monitoring team. Progress reports and report cards were reviewed regularly by the IDT. The facility continued to use a specialized ISPA form to document (and prompt) the IDT's review of pertinent aspects of the progress report or report card. These contained good information, including a statement about how the IEP was integrated into the individual's life at LSSLC. Thus, this appeared to be occurring, but perhaps was just not being adequately included in the written ISPs. Extended school year/summer programming for 2014 was not occurring. LSSLC provided a summer camp program for all of the students. This was good to see. At some point over the upcoming school year, extended school year for those students for whom it might apply, should be discussed with CISD.	
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.	There were improvements in this area. This item was rated as noncompliance, however, because only 53% of SAPs reviewed were clearly based on assessments, and functional skills assessments and preference and strengths inventories were not consistently 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. Tracking data from 1/14 to 6/14 indicated that an average of 80% of FSAs, 78% of the PSIs, and 91% of vocational assessments were competed 10 days prior to the ISP. This was an improvement from the last review when tracking data were not available, however, FSA and PSI assessments need to be more consistently competed 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	Noncompliance

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		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 17 SAPs, and nine of those (53%) had documentation that assessments were used to develop them. This represented an improvement from the last review when 42% of the SAPs reviewed included documentation that assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #551's SAP to learn to use headphones to listen to music was based on her preference (documented in her PSI and ISP) to listen to music. • Individual #526's PSI and ISP documented that he wanted to learn to read. Therefore, a SAP to teach him to identify letters was developed. • Individual #526's ISP documented that he was overweight and a SAP was developed to teach him to identify healthy foods. Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #128 had a SAP to apply lotion to her hands and arms. There was, however, nothing in her ISP, FSA, or PSI that suggested that this was a practical SAP for her, or that it was based on any assessment data. • Individual #402 had a SAP to learn to choose a scented lotion. There was nothing in her ISP, FSA, or PSI, however, that suggested that this SAP was based on assessments that indicated that this SAP was based on a preference or a need. The monitoring team observed a pre-ISP meeting for Individual #116. The team consistently developed Individual #116's SAPs based on assessments of preference, strengths, skills, and needs. 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 at least 85% FSA, PSI, and vocational assessments are completed at least 10 days prior to the ISP. Additionally, there needs to be documentation that at least 85% of SAPs reviewed were clearly based on assessment results.	

#	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. Fourteen of the 17 SAPs reviewed had at least three months of data. Nine of those 14 SAPs (64%) indicated SAP progress. This was a decrease from the last review when 90% of SAPs reviewed indicated progress. As found in the last review, there was not consistent evidence of data based decisions concerning the continuation, modification, or discontinuation of SAPs. For example, Individual #128 appeared to achieve the first step of her toothbrushing SAP in February 2014, but the same step continued through April 2014. An improvement from the last review was that LSSLC began to graph SAP progress. Monthly progress notes for nine of the 17 (53%) SAPs reviewed were graphed. This represented an increase from the last review when none of the SAPs reviewed had graphed progress. The consistent use of graphed data increases the likelihood that data based decisions concerning the continuation, discontinuation, or modification of skill acquisition plans consistently occurs. It is recommended that the facility ensure that SAP data are consistently graphed, and used to make based decisions concerning their continuation, discontinuation, or modification. As in past reviews, the implementation of SAPs was observed by the monitoring team to evaluate if they were implemented as written. For one SAP observed (Individual #560's SAP of focusing attention), the DSP did not appear to follow the SAP procedure following an incorrect response. As discussed in S1, however, the generic instructions following and incorrect response likely contributed to inconsistent implementation of SAPs. The other SAP observed, Individual #178 putting away towels, appeared to be implemented as written. He completed the task correctly and, therefore, did not require the DSP to address how to respond to an incorrect response. LSSLC conducted their own SAP integrity sessions to ensure that SAPs were	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 eight additional questions concerning the training across various components of SAP training (e.g., training schedule, consequences of corrects and incorrect responses, data collection). Additionally, since the last review the facility modified the scoring of SAP integrity so that the correct observation of the SAP represented 50% of the score. 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 across the facility. The ATCs conducted SAP integrity and indicated that the goal was to have one SAP integrity measure conducted for each individual per quarter. There were no data available at the time of the review concerning the frequency of SAP integrity collection, however, the self-assessment indicated that SAP integrity levels were at 99% for February 2014 to March 2014. 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 ensure that goal SAP integrity frequency (i.e., how often it is assessed) and levels (i.e., SAP scores) 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 frequency and levels.	
	(b) Include to the degree practicable training opportunities in community settings.	There have been improvements since the last review, however, more work is necessary for this item to be rated as substantial compliance. As discussed in past reviews, the majority of individuals at LSSLC participated in various recreational activities in the community. Additionally, since the last review, the facility established a data system to track the implementation of SAPs in the community. At this point, it is recommended that the facility now establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, 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 needs to establish acceptable levels of recreational and training activities in the community, and demonstrate 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: ○ Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments • State office guidance documents regarding special review process (November 2013) and potentially disrupted community transitions (December 2013) ○ LSSLC facility-specific policies regarding most integrated setting practices • Client Management-38, Most Integrated Setting Procedures, 11/1/13 ○ LSSLC organizational chart, undated, but likely June 2014 ○ LSSLC policy lists, 5/20/14 ○ List of typical meetings that occurred at LSSLC, undated but likely June 2014 ○ LSSLC Self-Assessment, 6/30/14 ○ LSSLC Action Plans, 6/18/14 ○ LSSLC Provision Action Information, 6/18/14 ○ LSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 7/14/14 ○ Admissions Placement Department meeting minutes, 2/3/14-7/7/14 (12 meetings) ○ APD staff community referral and transition logs for 20 individuals ○ Community Placement Report, last six+ months, 1/1/14 through 7/11/14 ○ List of individuals who were placed since last onsite review (11 individuals) ○ List of individuals who were referred for placement since the last review (17 individuals) ○ List of individuals who were referred and placed since the last review (3 individuals) ○ List of total active referrals (17 individuals) ○ 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) ○ List of individuals who were not referred solely due to LAR preference (32 of 71 ISPs since January 2014) ○ List of rescinded referrals (10 individuals) • ISPA notes regarding each rescinding (10 of the 10) • Special Review ISPA Team minutes for each rescinding (5 of the 10 [2 were for individuals who had an LAR, and 3 were rescinded in the last two weeks and SRT not yet conducted) ○ List of individuals returned to facility after community placement (0 individual) • Related ISPA documentation (not applicable) • Special Review ISPA Team minutes (not applicable) • Root cause analysis (not applicable)

	○ List of individuals placed in the past year, who experienced serious placement problems since the last review, 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 • 5 of 21 individuals who moved since 7/1/13, data as of 7/14/14 ○ Completed Potentially Disrupted Community Transition forms (5 for 5 individuals who moved within the last year and 3 for other individuals who moved between 12 and 18 months ago) • and ISPAs for other events that did not meet DADS' PDCT criteria ○ List of individuals who died after moving from the facility to the community since 7/1/09 (4, 1 since the last review) ○ List of individuals discharged from SSLC under alternate discharge procedures and related documentation (3 individuals) ○ APC reports • Detailed referral and placement report for senior management, (6) • Statewide one page weekly enrollment report (not requested) ○ Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair • Community tours • Work with local LA • Work with local providers • Facility-wide staff trainings/activities • For individuals • For families ○ Description of how the facility assessed an individual for placement ○ 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) ○ List of individuals who had a CLDP completed since last review (11) ○ Completed assessment checklist tool used by APC for 10 of the CLDPs ○ Documentation of day of move items (5 of 10) ○ Specialized transition plan for Individual #418 ○ QA related activities and documents • QA reports for last six months (3, monthly, April 2014-June 2014), includes graphs • QA QAQI Council presentations (2, March 2014, May 2014) • Completed self-monitoring tools for CLDP, post move monitoring, and alternate T4 transitions (one each, also included inter-rater agreement for each) ○ State obstacles report and SSLC addendum, March 2014 ○ LSSLC obstacles databases, one for referral and one for transition, 6/3/14 ○ PMM tracking sheet, 7/14/14 ○ Checklist given to St. Giles for documenting Individual #529's supports ○ Transition T4 materials for: • Individual #428, Individual #202, Individual #181 ○ ISPs for:

	• Individual #470, Individual #402, Individual #170 o Draft ISP used during the ISP meeting: • Individual #417 o CLDPs for: • Individual #457, Individual #408, Individual #164, Individual #307, Individual #311, Individual #309, Individual #349, Individual #484, Individual #400, Individual #529 o Draft CLDP for: • Individual #526 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 #225: 90 • Individual #23: 90 • Individual #505: 90 • Individual #292: 45, 90 • Individual #146: 45, 90 • Individual #457: P, 7, 45, 90 • Individual #408: P, 7, 45, 90 • Individual #164: P, 7, 45, 90 • Individual #307: P, 7, 45, 90 • Individual #311: P, 7, 45, 90 • Individual #309: P, 7, 45 • Individual #349: P, 7, 45 • Individual #484: P, 7, 45 • Individual #400: P, 7, 45 • Individual #529: P, 7 (observed by monitoring team) <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 staff: St. Giles <u>Observations Conducted</u>: o CLDP meeting for: • Individual #526 o ISP and pre-ISP meetings for: • Individual #417, Individual #116 o Living options discussion meeting for: • none

	○ Community group home and day program office visit for post move monitoring for: • Individual #529 ○ Senior management meeting/IMRT, referral review, 7/15/14
	Facility Self-Assessment The self-assessment should, but did not, line up with the content of the monitoring team's report. 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. The monitoring report now contains metrics within each provision. Each metric is preceded by a letter. The APC should use these to develop her next version of the self-assessment. For this review, the APC self-rated the following 10 provisions to be in substantial compliance: T1b, T1c, T1c1, T1c2, T1c3, T1e, T1f, T1h, T2a, and T4. The monitoring team agreed with five of these self-ratings (T1c, T1c2, T1c3, T1h, T2a). In addition, the monitoring team rated T2b in substantial compliance. The reasons for the differences in ratings are evident in the following review, but were primarily due to the self-assessment not looking all of the aspects of the provision that were looked at by the monitoring team, such as content of policies (T1b), content of CLDP supports (T1c1, T1e), an breadth of quality assurance programming (T1f).
	Summary of Monitor's Assessment The LSSLC admissions and placement department continued to make progress in most areas of section T. The number of individuals placed was at an annual rate of about 7%, a slight increase since the last review. 17 individuals were on the active referral list. 7 of the 17 individuals were referred for more than 180 days. Even so, reasonable activity and actions had occurred related to the transition and placement almost every individual. The transition specialists engaged in numerous activities each month regarding the individuals on their caseload. This seemed to have a positive effect on the pace of transitions. There were systemic issues delaying referrals. 45% of the 71 individuals whose ISPs were reviewed by the APC were not referred solely due to preference of the LAR. Obstacles to transition included the absence of providers who could meet the physical and accessibility needs of individuals, providers failing to return phone calls or emails from the transition specialists, and funding availability was cited as a barrier for three individuals. Independent recommendations from each of the professionals on the team were not presented and discussed during ISP meetings. Although there was some discussion regarding different types of living options, there was no discussion of barriers to referral and action plans to address those barriers.

	CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. LSSLC IDTs were highly involved in transition planning.. They visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, and responded to any problems exhibited by the individual. CLDPs did not clearly identify a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition, such as including sufficient detail regarding training of community provider staff, collaboration with community clinicians, and the assessment of settings by SSLC clinicians. The lists of pre and post move supports were not comprehensive and all inclusive. Discharge assessments provided a lot of information about the individual's current status at the facility, but they were more like annual assessments than discharge assessments. The APC was working directly with each discipline department to develop a discharge summary template that made sense for that discipline. The facility maintained substantial compliance with T2a and T2b. Post move monitoring was done thoroughly, on time, and in all settings. Issues and problems were identified and followed through to resolution. The PMM involve the IDT, provider, facility clinicians, and/or APC as necessary. She was a strong advocate for the individuals. Discharge summaries for alternative discharges (T4) were adequately prepared prior to the individual's move.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR,	<u>Placement Department Staff</u> The LSSLC admissions and placement department (APD) continued to make progress in most areas of section T. Although additional substantial compliance ratings were not achieved, much progress was found by the monitoring team, bringing the facility closer to obtaining substantial compliance. Some activities require months of preparation and then implementation in order to demonstrate substantial compliance. The entire APD staff remained the same since the last review, moreover, many of the staff had been working for a number of years in their current positions. This stability contributed to the progress made. The department was led by Lisa Pounds Heath, the Admissions and Placement Coordinator (APC). The other four staff were the Post Move Monitor (PMM) Mary Ramsey, Placement Coordinator Leigh-Ann Thomas, and Transition Specialists Cynthia Thigpen and Amanda Huckabee. Work assignments were made thoughtfully by the APC, such as assigning the placement coordinator primary responsibility for the CLDP finalization, and assigning caseloads to each transition	Noncompliance

	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.	specialist for supporting individuals, families, and IDTs through the transition process and ensuring that transitions did not stall. The facility closed the transition home that was described in previous reports. The facility director reported that they were considering some changes to on campus living, in part, to perhaps better support the minors living on campus and by having more behavioral health service involvement. <u>Transition-Related Numbers</u> Transitions: • The number of individuals placed was at an annual rate of about 7%, a slight increase since the last review, but overall, similar to the rate over the past few years. 11 individuals were placed in the community since the last onsite review. This compared with 9, 16, 7, 8, 13, 9, 8, and 5 individuals who had been placed at the time of the previous monitoring reviews. Referrals: • 17 individuals were referred for placement since the last onsite review, the most in any six-month period to date. This compared with 24, 19, 15, 7, and 14 individuals who were newly referred at the time of the previous reviews. o 3 of the 17 individuals were referred and placed since the last review. This compared with 3 at the time of the last review. • 17 individuals were on the active referral list. This compared with 19, 14, 18, 13, 17, 20, 25, and 17 individuals at the time of the previous reviews. o 7 of the 17 individuals were referred for more than 180 days. This compared to 1 at the time of previous review. o 0 of these 17 individuals were referred for more than one year. This compared to 0 at the time of previous review. <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 11 CLDPs of individuals who had been placed, 11 (100%) individuals and/or LARs did not oppose transition to the community. In all 3 of the ISPs reviewed, none of the 3 individuals were referred. <u>Responding to individual requests and rescinded referrals</u> There were 10 rescinded referrals since the last review. This compared to 10, 6, 3, 3, 4, and 4 at the time of previous reviews. Documentation (ISPA notes, ISPs, or SRT) was	

		provided for 10 of the 10 (100%) individuals regarding the reasons for the rescinding. Special review team meetings occurred for 5 of the 10 (50%). 2 of the individuals had an LAR and the APC reported that SRTs were not held for individuals for whom the LAR's preference was the reason for the rescinding. The other 3 rescindings occurred within the previous two weeks and the facility had not yet conducted the SRTs. b. Of these 10, the reasons for the rescinding appeared to be reasonable for 9 (90%). • One was rescinded because a provider could not be found (Individual #265). The individual had numerous mobility, care, and adaptive equipment needs, and required two staff to be present for lifts and transfers. The APD worked hard to find a provider and after many months agreed with the IDT's recommendation to rescind the referral. Thus, the rescinding occurred, not because the needs of the individual had changed, but because a provider could not be identified. • 2 were rescinded by family members who became the LAR after referral for the specific purpose of rescinding the current referral and preventing future referrals. o In none of these cases was evidence found that teams had developed detailed and individualized action plans to work with families to identify community living options that could address their specific needs and/or worked with state office or facility administration. Thus, this was inconsistent with the Settlement Agreement requirement that "the State shall take action to encourage and assist individuals to move to the most integrated settings…" • 6 were rescinded because the individual had serious health issues occur after referral. The IDTs rescinded the referrals with plans to discuss again in the coming months. • 1 was rescinded because the individual requested to stop the referral. He made visits to community homes and after speaking with his IDT, he clearly indicated that he wanted to remain living at LSSLC. 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. Therefore, of these reviews, actions were recommended in n.a. (n.a.%) cases. Of these, actions were implemented for n.a. (n.a.%). Some of the rescindings included a special review team meeting. During this meeting, a variety of senior staff from the facility reviewed the rescinding and commented upon it. In most, good suggestions were made for the individual's supports and how referral might be obtained and handled in the future. None of the documents, however, looked at what might be learned from these rescindings to improve the APD's practices in the	

		future. Once these discussions start occurring, they can be documented in a clearly identified portion of another existing document, such as within weekly APD meeting minutes. The rescinding of a referral should not be considered a failure and should not deter IDTs from referring individuals. A review for quality improvement purposes, however, should be conducted for all. c. 0 individuals were described as having requested placement, but were not referred. This compared with 0, 2, 2, 8, 6, 6, and 9 individuals at the time of the previous reviews. Therefore, this metric does not apply for this review: Of the n.a. 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. (n.a.%). The list of individuals not being referred solely due to LAR preference contained 32 names. This was based on a review of 71 ISPs conducted since January 2014. The APC was making her way through all of the ISPs to determine this information. This was the first time this data count was accurate (therefore, data from previous reports are not included here). Thus, 45% of the 71 individuals whose ISPs were reviewed by the APC were not referred solely due to preference of the LAR. <u>Systemic issues</u> d. There were systemic issues delaying referrals (at the state and/or facility level). • For a number of individuals, LAR choice was cited as the only obstacle to referral, but plans to provide guardians with viable choices for community living were not included in ISPs, nor did they appear to exist on a systemic level. This was further supported by the APC's recent detailed review of 71 ISPs that showed that 45% of those individuals would have been referred if not for the LAR's preference. ○ On the other hand, Individual #484's brother, his LAR, was opposed to placement, but after responding to staff's requests for him to visit community providers, he agreed to referral. The APD staff specifically addressed his concerns about behavior management in the community by setting up opportunities for him to visit providers, observe group homes, and talk with provider staff and managers. • The facility identified lack of staff and individual knowledge as an obstacle to referral and created a corrective action plan (CAP). The CAP activities were to increase the number of provider fairs and tours, have the new placement coordinator visit with IDTs, and try to shorten the requirements for the IDT to make a referral. It was unclear if the CAP was having any effect at the time of this review. The CAP did not have measurable outcomes.	

		e. There were existing and/or potential systemic issues delaying transitions (at the state and/or facility level). Given that 40% of the LSSLC active referrals were more than 180 days old, an examination of obstacles to transition remains warranted. Many transitions were slowed by: • The absence of providers who could meet the physical and accessibility needs of individuals. In one case, the facility rescinded the referral, in others, they had passed 180 days. • Providers failing to return phone calls or emails from the transition specialists. Some providers were not responsive for weeks, sometimes not for months. • Providers failing to make home renovations and adaptations in a timely manner. It was unclear if the delays were due to provider management competence, funding availability, or contractor delays. The APC had a database list of various individuals and their obstacles to transition. This was a good start. The data would be more useful if it indicated the criteria for determining if there was an obstacle to transition, if-when-how the obstacle was overcome, and summarization of data. This information then could be very useful for the APD staff's planning for future transitions, using APD resources, and working with state office and facility administration. f. Funding availability was cited as a barrier to three individuals moving to the community. Three examples are below. • Individual #265 required two staff for transfers. • Individual #151 required some sort of specialized bladder scanner. • Individual #424 may have exhausted her lifetime insurance coverage for oxygen-related items. The facility was working with the provider and with the individual's insurer to resolve this, however, many months had passed, delaying her transition. 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. She also completed a weekly status report that was very useful to senior managers and others interested in the status of referrals at LSSLC. <u>Pace of transitions</u> h. Transitions were occurring at a reasonable pace. To make this determination, the monitoring team reviewed CLDPs, ISPs, ISPAs, 180 day meeting notes, any APD meeting minutes or reports, the APC's weekly enrollment report, and various emails	

		and meeting minutes. LSSLC did a particularly good job of documenting the activities taken by the transition specialists and other members of the APD. In addition to the above documentation: • Each transition specialist maintained a log of all transition-related activities for each individual on her caseload. Thus, it was easy to understand the frequency and sequence of activities for each individual. • The APC held a meeting of her staff each week with a standard set agenda of various relevant topics. Detailed minutes were kept. Topics included APD staff schedules, status of referrals, post move monitoring, and discussion of any problems occurring after placement (including PDCTs). 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 sample of 11 individuals placed since the time of the last onsite review, 9 (82%) were placed within 180 days of their referral (i.e., 2 were not). o 2 of the 11 were placed within two weeks of having passed the 180 day marker. • At the time of the review, 17 individuals were referred for community transition. 10 of these 17 (59%) had not exceeded the 180-day timeframe (i.e., 7 had exceeded 180 days). o Of the 7, 0 individuals had exceeded one year (though two were close to one year). The two individuals who were placed after more than 180 days, and all 7 of the individuals on the referral list for more than 180 days (i.e., a total of 9 individuals) were chosen for determining the ratings of metrics i., j., and k. i. Reasonable activity and actions had occurred related to the transition and placement for 8 of the 9 (89%) individuals. IDTs met most months for the individuals who were past 180 days on the referral list. Although this was not a Settlement Agreement requirement, it was part of the state's policy and would improve the facility's documentation of IDT activity regarding these transitions. • Of the sample of 7 individuals referred for more than 180 days, reasonable activity was taken for 6: o One individual was transitioning to another state. No documentation was provided to indicate if activities were occurring. • Of the sample of 2 individuals who were placed after being on the referral list for more than 180 days, reasonable activity and actions were taken for 2.	

		• The transition specialists engaged in numerous activities each month regarding the individuals on their caseload. This seemed to have a positive effect on the pace of transitions. ○ Even so, the obstacles to transition cited above were ones that were unable to solve on their own. They will require the assistance of facility administration and state office. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for 8 of the 9 (89%) individuals. k. Adequate justification was provided for the lengthier transition process for 8 of the 9 (89%) individuals.	
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. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: “Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spelled out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and facility’s responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes,	Noncompliance

		provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken <u>prior</u> to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. • There was no mention of need for the IDT to use CLDP to ensure supports are in place. • The policy listed two reviews of CLDPs to be undertaken, one at the facility and one at state office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. o The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. <u>Facility policy</u> b. There were not facility policies that supported the state policy for most integrated setting practices. • The facility should have policies and procedures that operationalize/define implementation of the parts of the state policy that are not specific. 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. Training of facility staff on policies is addressed in T1b2 below. 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.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety	This section relates to the activities of the IDT, QIDP, and the ISP process. The APC and QIDP coordinator should work together to address these topics. They should be able to adequately address the metrics in this provision (T1b1) as well as the other ISP-related provisions of section T, which include T1b2 item#1, and all of T1b3. The monitoring team recommends that the APC and QIDP coordinator begin to collect data on these same	Noncompliance

	and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	metrics as does the monitoring team. <u>Protections, services, and supports</u> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted in section F, substantial compliance was not found for F1d, F2a1, and F2a3. For the sample of 5 individuals who's CLDPs were reviewed (see below), 0 individuals had SAPs developed and implemented to help prepare the individual for his or her transition during the period between referral and placement. <u>Obstacles to movement</u> The monitoring team reviewed a sample of 3 ISPs and observed the conduct of 1 annual ISP meeting for monitoring of this provision. ISPs were submitted by the facility and included individuals from each of the units. The facility submitted 9 ISPs, however, 6 of them were conducted during the week of the previous monitoring review and, therefore, were not included in this review. While onsite, the QIDP coordinator and the facility director said that this set of ISPs (and attachments) were representative of the current work being done at the facility (i.e., there was no need to look at any more recently completed ISPs). Regarding referral at the individual level: b. Of the 3 ISPs reviewed, 3 should have had obstacles <u>to referral</u> defined (0 were referred for transition to the community). Of these 3 ISPs, 0 (0%) included an adequate list of obstacles to referral. Obstacles to referral for 2 were LAR preference, but the correct reason for the LAR's preference (from the state's list of options) was not selected. For the third individual, her family members preferred her to live at LSSLC (though none was appointed as LAR), however, the ISP stated the reason for no referral was due to the individual's choice (however, the individual was unable to provide a preference). c. Of the 1 annual ISP meeting observed, an adequate list of obstacles <u>to referral</u> was identified for 1 (100%). Obstacles were her mother's preference/hesitancy and some medication/medical issues. A plan to address obstacles at the individual level: d. Of the 3 ISPs, 0 (0%) included an action plan to address/overcome obstacles identified. Of these n.a., n.a. (n.a.%) were adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). e. Of the 1 annual ISP meeting observed, a plan to address/overcome the identified	

		obstacles was included for 0 (0%). Of these, n.a. was adequate. The individual's mother raised questions regarding services in the community and whether the individual could return to LSSLC if community placement did not work out. The team did not provide answers to her questions or develop adequate outcomes to provide further education to the individual's mother. The team agreed that she could visit community providers, however, a timeline for doing so was not established. Overall, there was an absence of action plans that directly lined up with the actual obstacles or the reasons behind the obstacles (i.e., the reasons for LAR preference). The ISPs stated broad activities regarding providing the LAR with information annually. Further, the activities were appointed to the LA, thus, removing the facility staff from any responsibility for any actions. Regarding transition at the individual level: f. Of the 5 CLDPs (and related ISPAs) reviewed, 0 should have had obstacles <u>to transition</u> defined. Of these n.a. CLDPs, n.a. (n.a.%) included an adequate list of obstacles to transition. g. Obstacles to transition were defined for n.a. individuals. Of these, n.a. (n.a.%) had action plans to address the obstacle <u>to transition</u>. There were no obstacles to the transitions of any of the 5 individuals. The facility's process of provider identification, pre placement visits, and CLDP development were implemented. <u>Preferences of individuals and LARs</u> Preferences of individuals are determined and described: h. Of the 3 ISPs, 0 (0%) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). • 1 of the 3 was unable to clearly provide a preference. For the other 2, LARs requested that the facility and LA not have any conversations or presentations about community living to the individuals. i. Of the 1 annual ISP meeting observed, the individual's preference for where to live was adequately described in 0 (0%), and this preference appeared to have been determined in an adequate manner for 0 (0%). Preferences of LARs are determined and described: j. Of the 3 ISPs, an LAR was appointed for 2. Of these, 2 (100%) included an adequate description of the LAR's preference and how that preference was determined by the IDT.	

		k. Of the 1 annual ISP meeting observed, the LAR's preference for living setting was adequately described in 1 (100%), and this preference appeared to have been determined in an adequate manner for 1 (100%).	
	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.	1. Individualized plan: a. In reviewing 3 recently completed ISPs, 0 individuals had been referred for placement and were engaged in the CLDP process. For the remaining 3, 0 (0%) had a plan that addressed education about community options. Therefore, the following metric could not be assessed: Of these, n.a. (n.a.%) were adequate. Regarding the plans for education in this set of 3 ISPs: • 0 of the 3 (0%) had a list of activities that was individualized and specified what will be done over the upcoming year. To meet criteria with this metric, the plan should go beyond a generic provision of information; it should reflect the specific concerns that individuals and families/LARs have raised about the community, as well as reflective of the individual's needs. o The most challenging area with regard to education of individuals and LARs/families is individualizing this process. Action plans should target specific types of providers for community tours, identify research that the team would do to answer the individual/LAR's specific questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans to address the reasons for the individual, family member, or LAR's reluctance/preference. For example, if an LAR has questions or concerns about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. When teams have questions about availability of supports in community settings, these should be researched. o In the 1 ISP meeting observed during the onsite review, an individualized plan was not discussed or created. • 0 of the 3 (0%) were in measurable terms and provided for the team's follow-up to determine the individual's reaction to the activities offered. • 3 of the 3 (100%) included the LAR, as appropriate, based upon the content of the ISP. However, the actions were the same for all ISPs, that is, that the LAR would receive information annually. The actions were not individualized for the individual or the LAR. • 0 of the 3 (0%) adequately described how/if the previous year's plan was completed. The ISP prep document indicated that the actions were	Noncompliance

addressed, but provided no detail about what occurred and how it might be changed for the upcoming year.

It may be helpful to:

1. Add some prompts or headers to the ISP shell to help the IDT address each of the above four bullets.
2. Have the transition specialist who attends the ISP meeting ensure that the IDT always adequately addresses these four bulleted items.
3. Review this, with data, with the APC and QIDP coordinator.

2. Provider fair:

b. The facility did not hold a provider fair within the past 12 months.

3. Local MRA/LA:

c. The facility did appear to maintain good communication and a working relationship with the LA. The facility did not participate in quarterly meetings with the LA (only one meeting held in the last six months, in February 2014). Relevant topics were on the agenda for the LA meeting.

4. Tours of community providers: All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to).

d. The facility did not have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, identified all individuals and whether or not each went on a tour). Since the last review, there were seven tours, one each month in January 2014, February 2014, and April 2014; and two each month in May 2014 and June 2014. Twenty-seven individuals went on tours; some were already referred, some not. Notes regarding the experience for some of the individuals for some of the tours were written by staff attending the tours. The APC said that this information was given to the QIDP for the IDT. The APC reported that they were going to increase the number of tour opportunities per month.
    - To meet this aspect of T1b2, the facility needs to demonstrate that:
        - All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours).
        - Places chosen to visit are based on individual's specific preferences, needs, etc.
        - Tours are for individuals or no more than four people.
        - Individual's response to the tour is assessed.

e. The facility did not have data for the following metric: Based on the facility's own report, of the n.a. individuals at the facility for whom a tour was appropriate, n.a. (n.a.%) went on a tour appropriate to their needs within the past year.

		f. Of the n.a. individuals in the sample for whom their teams had determined a tour was appropriate, n.a. (n.a.%) went on a tour tailored to their needs within the past year. To meet the standard for this item of T1b2, at least 90% of the individuals for whom a tour was appropriate should have attended a tour. <u>5. Visit friends who live in community</u>: g. The facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. <u>6. Education activities at/by facility for individuals</u>: h. Since the last onsite review, other educational activities for individuals did not occur during self-advocacy meetings, did occur during house meetings for individuals in three homes for a total of 31 individuals, did not occur during family association meetings, and did not occur during any other situations or locations. The educational programs in the three homes were conducted by the LA and included video about community homes. <u>7. Education activities for direct support professionals (DSPs), clinicians, and managers</u>: i. More than 75% of DSPs were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). j. More than 75% of clinicians were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). k. More than 75% of managers and administrators were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). <u>8. Reluctant individuals/LARs learn about successes</u>: l. Since the last onsite review, information about successful community placements was not shared with (a) individuals who were reluctant to consider community placement, and (b) LARs who are reluctant to consider community placement. • The facility did not have a process for this to occur.	
	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,	The monitoring team requested a set of recent ISPs, attachments, and assessments. Three were selected for review by the monitoring team (see above under Documents Reviewed and description in T1a). Due to the limited sample, these were from two units, across three different QIDPs. The ISPs were from meetings held in February 2014.	Noncompliance

	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.	1. Professionals provided recommendation in assessments: a. Assessments were reviewed for 3 of the 3 ISPs. Of the 3 ISPs reviewed, all of the assessments for 0 individuals (0%) included an applicable statement or recommendation from all disciplines. • The ISPs sampled were for individuals who were not referred. • Assessments were completed for all disciplines. • The state office new standardized statement/requirement was not being used by all disciplines all the time. • Below are some data for these 3 ISPs: Discipline # assessments # with a statement # w/ state statement Medical 3 of 3 3 of 3 0 of 3 Nursing 3 of 3 3 of 3 1 of 3 Dental 3 of 3 3 of 3 0 of 3 Psychiatry 1 of 3 1 of 1 1 of 1 Psychology 3 of 3 3 of 3 2 of 3 Pharmacy 3 of 3 0 of 3 Habilitation 3 of 3 3 of 3 0 of 3 Nutrition 3 of 3 3 of 3 3 of 3 Aud./Vision 3 of 3 0 of 3 Residential 3 of 3 1 of 3 1 of 1 Educ./Train 2 of 3 2 of 2 2 of 2 Vocational 1 of 3 1 of 1 0 of 1 Social Work 3 of 3 3 of 3 0 of 3 2. Professional determinations presented/discussed at ISP meeting: b. In 0 of the 3 (0%) written ISPs reviewed, and during 0 of the 1 (0%) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included. • Statements were copied from the assessments and inserted into the written ISP for all of the assessments. • The ISP did not note whether these professional determinations were stated verbally during the ISP meeting. The monitoring team believes that these were not presented during the meeting. • During the ISP meetings observed, all IDT members did not have the opportunity to provide their opinions (e.g., Individual #417). The psychiatrist and medical staff recommended any consideration of referral be delayed due to medication changes. After this, no other team members gave his or her opinion. If they had, a more robust discussion of referral and living options would likely have occurred.	

		3. Thorough discussion of living options at ISP or other IDT meeting: c. In 0 of the 3 (0%) written ISPs reviewed, and during 0 of the 1 (0%) annual ISP meetings observed, a thorough discussion of living options occurred. • Living options discussions were not adequate. Although there was some discussion regarding different types of living options, there was no discussion of barriers to referral and action plans to address those barriers. • At the pre-ISP meeting for Individual #116, the IDT briefly reviewed her permanency plan. They acknowledged that the family did not want her to move because they were afraid that she could not return to LSSLC if placement did not work out. The team agreed to talk more about it at the annual meeting and reassure her mother that she would not be stuck in a bad placement. The behavioral health specialist stated that he thought she would do better in a smaller environment. Other team members did not contribute their opinions to the discussion. The team reviewed her outcome for the family to attend a provider fair and noted that it had not been implemented. The team agreed that living option outcomes needed to be developed at the annual meeting. 4. IDT determination in written ISP: d. In 3 of the 3 (100%) written ISPs reviewed, a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included. • In all 3 cases, the IDT would have referred if not for the preference of the LAR or family. e. In 3 of the 3 (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included.	
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 10 CLDPs completed since the last review. This was 91% of the 11 CLDPs completed since the last review. The monitoring team reviewed 5 of the 11 (44%) CLDPs in depth. Timeliness of CLDP Initiation of CLDP a. 5 of the 5 (0%) CLDPs were initiated within 14 calendar days of referral. The monitoring team based this finding by reviewing documentation of CLDP-related activity occurring within 14 days of referral, including the actual 14-day meeting minutes or indication on the CLDP cover/first page. Some of the dates appeared to be incorrect on the cover/first page, which the APC reported were now corrected. 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. Evidence	Substantial Compliance

		was found within the CLDP section IV., in ISPA notes, and/or in the transition specialists' logs. <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). The LSSLC IDTs were highly involved in transition planning. Examples included pursuing additional homes when a first home was deemed somewhat acceptable, but not as good as the IDT thought (correctly) could be found, for Individual #307. For Individual #529, the IDT identified two providers that were equally appropriate. The team engaged in thoughtful discussion considering the pros and cons of each provider and ultimately made what appeared to be a good decision for the individual. <u>Coordination of CLDP with LA</u> d. -- of the 5 (n.a.%) CLDPs or other transition documentation included documentation to show that the facility worked collaboratively with the LA. The monitoring team chose to not rate this metric because 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.	
	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. The monitoring team reviewed all six in detail with the APC and placement coordinator, and suggested including six short bullets within CLDP section IV. The monitoring team understands that not all six of these bulleted items will apply to every individual, however, there should be some indication that all six were at least considered by the IDT and placement coordinator in the development of every CLDP. The absence of any comment in the CLDP indicates that these important aspects of transition were most likely overlooked. • Training of community provider staff, including staff to be trained and level of training required. Three of the CLDP included all training for all staff within a single pre and/or post move support.	Noncompliance

		i. who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), 0 of 5 (20%). The CLDPs said staff, or day and residential 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), 0 of 5 (0%), and iii. a competency demonstration component, when appropriate, 2 of 5 (40%). • Collaboration with community clinicians (e.g., psychologist, behavior health specialist, psychiatrist, PCP, nurse, SLP). This was noted in 3 of the CLDPs (60%). These were for nurse to nurse for Individual #408 and Individual #307, and for psychiatrist to psychiatrist for Individual #529. If collaboration with community clinicians was considered by the IDT and perhaps deemed not necessary, the CLDP should indicate this decision. Further, for the CLDPs that indicated one type of clinician (e.g., nurse, psychiatrist), the CLDP should indicate that the IDT determined it was not necessary for other clinicians. Moreover, sometimes there is clinician to clinician contact before the CLDP meeting occurs. If so, it could be noted within this bullet, if the facility decides to include six short bullets within section IV. • Assessment of settings by SSLC clinicians (e.g., OT/PT). This was noted in 1 of the 5 CLDPs (20%), that is, for Individual #307. Clinicians viewed her bedroom regarding space, layout, and heating/cooling (and determined it was acceptable). • 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. o On the other hand, an individualized transition plan was developed for an individual who was not part of this sample (Individual #418). The facility and provider created a detailed schedule that included provider staff spending time with the individual at the facility and then facility staff spending time with him at his new group home and day program. This was good to see and something that LSSLC had done for other individuals over the past year. • Collaboration between Post-Move Monitor and Local Authority staff. This was not noted in any of the CLDPs, but the PMM and APC reported that every post move monitoring report was sent to the LA for all 5 individuals (100%).	

		Documentation of day of move activities 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. Documentation for 3 of the 5 (60%) indicated that the activities did indeed occur. For Individual #309, the documentation was completed by facility staff, but not verified/signed by the provider. CLDP meeting prior to moving A CLDP meeting occurred for 5 of the 5 individuals (100%). It was described in each of the CLDPs. c. A CLDP meeting occurred during the onsite review for Individual #526. The meeting ran very well with lots of participation from IDT members, the community provider (Allen Gould, A-Trinity program), and the mother (via speakerphone). The individual also attended, though his participation was limited. The placement coordinator did a nice job of keeping the meeting moving along. Further, she attempted to determine which aspects of the individual's PBSP should be specifically identified in the list of post move supports. There was excellent participation from many members of the IDT. The DSP II staff member actively participated and provided very useful information to the new provider. The monitoring team observed all of the following aspects of a CLDP 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.	Staff names provided for all pre- and post-move supports a. For 5 of 5 CLDPs (100%), the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and title for each pre-/post-move support. Completion timeframes/dates for all pre-/post-move supports: b. For 5 of 5 CLDPs (100%), the facility identified specific timeframes/specific dates for completion and/or implementation for each pre-/post-move support. The timeframe for many of the supports was written as "ongoing" and then the due dates of post move monitoring were given. Instead, the date that the support needs	Substantial Compliance

		to be in place should be in this part of the CLDP. It might be the day of the move, or it might be by day seven, for example. After giving this date, the facility can also add the wording "and ongoing."	
	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.	Evidence of individual/LAR participation: a. Based on review of 5 CLDPs, 5 (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by: • signatures on CLDP • narratives in the CLDP	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	In preparation for the CLDP meeting, assessments were updated and summarized prior to the CLDP meeting. This provision remained in noncompliance, however, the APC and the facility took a number of actions over the past few months to improve the quality and usefulness of the discharge assessments. The APC developed and implemented a corrective action plan (CAP). It was newly implemented and included the APC working directly with each discipline department to develop a discharge summary template that made sense for that discipline and that included the necessary content, especially regarding recommendations for the new provider and the new home and day locations for the individual. The APC planned to review every discharge assessment with her own review tool. Overall, the current assessments provided a lot of information about the individual's current status at the facility, but they were more like annual assessments than discharge assessments. For instance, many of the assessments recommended transition to the community, which made no sense because the individual was moving to the community and a specific provider, home, and day site were already identified and known to the IDT. The following review was based on the discharge assessments from the 5 CLDPs reviewed by the monitoring team. <u>The assessments selected for completion are appropriate and none are left out</u> a. For 2 of the 5 CLDPs reviewed (40%), all necessary assessments were completed. • Three of the individuals should have had a discharge assessment from psychiatry. <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. • The APC did a good job of monitoring this variable.	Noncompliance

		<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 four closed bullets: • A summary of relevant facts of the individual's stay at the facility. o The content of the assessments for some, but not all, 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 Some of the assessments for all 5 individuals were thorough enough to assist teams in developing a list of 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 set of 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. Some additional detail regarding nursing discharge assessments if found in section M.	
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-	The lists of pre-move and post-move supports were identified in the CLDPs. There was a lot of improvement in the lists of supports, however, more work was needed. In addition, good information was included in section IV of the CLDP (though more was needed as described below). The monitoring team again recommends that the APC conduct a self-assessment type review of each CLDP before finalizing it to ensure that the components of sections T1c1 and T1e are adequately addressed. The monitoring team spoke about this at length with the placement coordinator (she had primary responsibility for the finalization of the CLDPs and for leading/facilitating the CLDP meetings), APC, and PMM.	Noncompliance

	essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	<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. Similar to section T1c1 above, not all of these items will apply to every individual, but each should be considered in the development of every CLDP. If this was being done, more of the items below would be present in the list of pre and post move supports, or some indication of their consideration by the IDT would be written in the deliberations/discussion paragraph for the corresponding clinical area. 1) The list is comprehensive and inclusive, demonstrated by the following eight open bullets: ○ Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This applied to 5 of the 5 individuals, and was demonstrated in 0 of the 5 (0%). Merely saying to "continue the PBSP as written" was insufficient. Further, the CLDPs and PBSPs detailed many aspects about interaction style, communication, preferences, clothing, food, music, schedules, and so forth that were critical to each of these individual's success. This was the case for all 5 CLDPs. In particular, in two of the cases, the behavioral health specialist listed in his discharge assessment, three or four aspects of programming that were important for the individual, such as working on specific replacement behaviors and implementing previously-successful preventive strategies (the lists for both individuals, however, were almost identical, begging the question of whether these were individualized recommendations or the standard recommendations always given by this behavioral health specialist for every discharge assessment that he wrote). • The post-move support for Individual #408 said to continue his BSP, but there were no references to two aspects of his current programming at LSSLC: 15 minute nighttime bed checks and remaining within 20 feet of staff from 6 am to 10 pm. • Individual #307's history of taking food from other individuals and eating inedibles/pica were not addressed. • Individual #309's list of supports had no contributions from psychiatry regarding his depression, and nothing about the prevention strategies noted in numerous assessments. • Individual #484's list of supports only said to continue	

		BSP, whereas he should have had a support to address the important replacement behaviors that were being taught at LSSLC. Further, the CLDP noted that he was extremely anxious about moving, but there were no supports to address this. ▪ More should be garnered from psychiatry. ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the facility should be modified in a community setting. This was not in any of the CLDPs, but should have been for anyone with a history of behavioral and/or psychiatric issues. o All safety, medical, healthcare, therapeutic, risk, and supervision needs were addressed. ▪ This applied to all 5 individuals and was adequately done for 3 of the 5 (60%). Examples included safe eating such as tucking chin, preparing pureed food and honey thick liquids, pica sweeps, pocket checks, presence and use of adaptive equipment, and regular exercise. Aspects not addressed were use of TED hose and a high rate of sick calls during the six months prior to moving (Individual #309) and recent 20 pound weight gain (Individual #484). ▪ The need for an LAR should also be discussed. This might have been an appropriate support for Individual #307. 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 5 of 5 (100%). The CLDPs had separate post move supports for preferred activities and items that should occur at home and those that should occur in the community. This was good to see. There were individualized, such as obtaining adult education and a GED for Individual #484. o The list of supports thoroughly addressed the individual's need/desire for employment, and/or other meaningful day activities. ▪ Employment or day supports applied to 5 of the 5 individuals and was adequately addressed for 2 (40%). The discharge assessments and other documents (e.g., PSI, ISP) for the other three individuals clearly stated that employment was important to them, however, they were assigned to day hab programs (Individual #408, Individual #309, Individual #484). The CLDP for Individual #309 noted that his vision was to be employed at a pet store.	

		○ 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 addressed in 0 of the CLDPs (0%). Positive reinforcement applied to all individuals and probably played a considerable role in their success at the facility. ○ 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 addressed for 5 (100%). ○ In some CLDPs, two separate supports were included, one for skills to be taught at the day program and one for skills to be taught at home. This was a good way of providing more direction to the providers. ○ The supports say the skills should be taught informally or formally. The monitoring team suggests that this be specified. Likely, providers will choose to do skill training informally if given the choice. Formal skill training increases the likelihood that training will be done regularly and consistently. ○ One of the skills for Individual #309 was to participate in a group activity. This seemed to be more of a participatory support rather than a skill to be learned. ○ There were pre-/post-move supports for the provider's <u>implementation</u> of supports for 1 of the 5 (20%). This refers to the components of the PBSP, 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 were not included. ○ All recommendations from assessments are included; or if not, there is a rationale provided. This occurred for 5 of the 5 CLDPs (100%). ▪ For the most part, recommendations were included. ▪ The APC or placement coordinator wrote very detailed narratives of the discussion and deliberation that occurred for each of the disciplines during the CLDP meeting and how the discussion led to a set of what they called final recommendations. 2) The wording of every pre-/post-move support is in measurable, and observable terms. ○ Most were in measurable terms, however, many continued to include wording, such as increase activity level, implement current BSP as written, and RN case management will be provided.	

		○ There was usually a list of four or five preferred items of activities within the same support. The support provided a criterion, such as engage in preferred activities once per week (for community activities) and daily (for in home activities). The support, however, should define if the IDT wants the individual to experience all of these. For instance, in the current format, criterion would be met if the individual only experienced one of his five preferred activities each week whereas the intent of the IDT was for him to experience all of his preferred activities. However, the LSSLC PMM reported on the individual's participation in each of the preferred activities (e.g., Individual #408), which was very good to see, informative to the IDT, and suggests that an option is for the CLDP to ask for the PMM to report in this manner. 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. ○ This was much improved and included more references to logs, checklists, and interviews. <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 conducted the LSSLC pre move site reviews. She was very detailed in her pre move reviews. One example was her identification of three potentially serious issues during the pre move site review for Individual #307 that would likely have occurred if not for her intervention. These were an improper lock on the bedroom door leading to the outside (the provider also put in a door alarm), a door lock that was installed backwards, a cigarette butt can on the patio but the individual had pica behaviors, and absence of a personal shower chair. The PMM made two additional pre move visits to the home to ensure all of this was corrected before the individual's move date (similar follow-up was done via photograph evidence prior to the move of Individual #400). e. For___ of __ (%) pre-move site visits observed by the monitoring team (if any), the pre-move site visit was conducted thoroughly (not applicable, none were 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.	Policy/Procedure a. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. • The state recently developed and disseminated the beginnings of a section T/most integrated setting practices QA program to each of the facilities. It included three tools to assess the written completed CLDP document, written completed post move monitoring forms, and the written completed transition document for provision T4 type transitions. It included two sets of instructions (one page each). One was for the conducting of the three tools. The other was regarding the full set of transition-related data and review system. • The content of the three tools lined up better than ever before with the content of the monitoring team's metrics and reports. The state should again review the Monitors' reports for the next revision of these tools. o The APC was implementing all three of these, including obtaining some interobserver agreement with QA department staff. This was all good to see. The data, however, were not yet summarized, trended, analyzed, or included in the QA program. One example of each was given to the monitoring team. Ratings were very high for the CLDP, different than the findings of the monitoring team. Interobserver occurrence agreement was high for all aspects except for the content of the discharge summaries. • Tools regarding the important ISP-related components of section T were not addressed (e.g., T1a, T1b1, T1b2, T1b3). o The APC reported that these were supposed to be part of the section F ISP monitoring tool. As a result, she said that they were using the old living options monitoring tool (though its problems have been noted in previous monitoring reports). • The facility should have its own facility-specific policy/procedure for quality assurance to meet what is required by this provision T1f. Collection of data b. Data/information were not being collected (i.e., although a small set of data was reported, a complete set of data was not being collected). The data that were being collected were relevant and valid. The data appeared to being collected reliably. • The monitoring team has, for some time now, suggested the following set of data to contribute to the APC's QA program and to set the occasion for summation, review, and analysis of data. These are simple data to collect and graph. Some time might be required for the initial set up of data charts and graphs, but once done, will only require a monthly entry of a data point that the APC should be collecting and reporting on anyway. Only three items were being reported (indicated with check marks).	Noncompliance

		1. √ Number of individuals placed each month or monitoring period 2. √ Number of new referrals each month or six-month period 3. Number of individuals on the active referral list as of the last day of each month 4. Number of individuals on the active referral list for more than 180 days, as of the last day of each month 5. Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers). 6. Number of individuals who have requested placement, but have not been referred, as of the last day of each month 7. Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month 8. Number of individuals not referred solely due to LAR preference as of the last day of each month 9. Number of individuals who had any untoward event happen after community placement each month (including return to the facility or death) ▪ Cumulative number of each type of untoward event for all placements (returns, deaths) ▪ number that had a root cause type review 10. √ Number of rescinded referrals each month or each six-month period ▪ number that had a root cause type review 11. Number of alternative discharges (T4) 12. Number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles (from T1b1) 13. Number of individuals who went on a community provider tour each month and total number/percentage of individuals who went on a tour in the past 12 months (from T1b2) Summarization/analysis of data and actions taken c. Data were reviewed and somewhat summarized (in a single sentence, or two), but not analyzed. There was no narrative or explanation of the data. Actions were not taken as a result of analysis of the data. The data were included in the facility's QA program and presented quarterly to QAQI Council. The most recent presentation was May 2014 and most recent data were submitted to QA on 7/10/14 (data through June 2014). A more complete set of data, with at least year 12 months of trended graphed data will be more useful to the APC than the current very limited set of data, much of which, if graphed at all, was graphed for the previous three to	

		five months only. The APC reported that two corrective action plans were implemented since the time of the last review. One was to increase the number of referrals and the other was to improve discharge summaries. Both were important topics and ones for which action was appropriate, and it was good to see that actions were being taken. Neither referred to current data or target levels of performance. Re-admissions: There were 0 re-admissions. This compared with 1, 1, 0, 0, 0, and 2 re-admissions at the time of all of the previous reviews. Therefore, the following metric did not apply for this review. d. For n.a. of the n.a. (n.a.%) who returned to the facility after a failed community placement, an adequate review was conducted to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in n.a. cases. Of these n.a. cases, actions were implemented for n.a. (%). Deaths Following Community Placement: There was 1 death of an individual who had moved to the community. This compared with 1, 0, 0, 0, 0, 0, and 2 deaths prior to previous reviews. e. 1 individual who transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the facility should be made for 0 (0%) of the cases. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for ___ (%). Other Adverse Outcomes: f. Over the past six months, 5 of the 21 individuals placed in the past year (24%) experienced one or more potentially negative outcomes since placement. Of these, there was an adequate review conducted for 0 (0%) of the cases to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in n.a. cases. Of these n.a. cases, actions were implemented for (n.a.) (%). The facility maintained data on all occurrences, above the state office PDCT criteria. This was good to see. The monitoring team reviewed ISPAs, completed PDCT forms, and the ADP meeting minutes. Within the ISPAs and PDCT there was no discussion regarding any quality improvement changes or considerations to referral and transition processes. The data, however, showed that two of the five individuals moved to new providers because the LAR was not satisfied with the care given to the individual, and that two	

		others were hospitalized due to g-tube problems. This points to at least two areas that deserved more discussion. The fifth individual was hospitalized due to a medication side effect. These incidents and possible quality improvements could be documented in the APD meeting minutes. The monitoring team's review of these minutes identified some general quality improvement-related comments, but the monitoring team could not determine if these were implemented or monitored. Examples were general comments on 3/10/14 about ensuring that habilitation therapy is present at all CLDP meetings (Individual #164), and documenting via a checklist that all adaptive equipment is delivered for pre placement visits (Individual #70); on 4/14/14 about ensuring all disciplines are present at CLDP meetings; and on 6/30/14 about sending more cash on the move date because it often took too long for the individual's cash to become available.	
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	Annual narrative by facility a. The facility did not have an adequate system to collect information about obstacles to transition. • The monitoring team found that obstacles were not adequately identified in the ISPs. To correct this, the APC was planning to work with the QIDP Coordinator (though this had not yet occurred). She was also reading every ISP to make a determination as to the actual obstacle to referral (because the coding system was not being used correctly or thoroughly). At this point, she had reviewed 71 ISPs and found that 45% of the individuals were not referred <u>solely</u> due to LAR preference. Similarly, her obstacles to transition database (for those already referred) required additional work, such as determining the criterion for inclusion in this database, tracking length of time to overcoming the obstacle (if it was overcome). • The facility's data system, when completed, should also indicate if any "compromises" of the individual's needs, preferences, and/or supports were required in order for the transition to occur. An example of a compromise would be if the individual "settled" for a day habilitation program because the vocational program that the team recommended (or that the individual preferred) was not available in the part of the state in which the individual/guardian wanted to live. Another example would be if the individual moved to an area of the state that was not the original preference because clinical services were not available there. b. The facility did not have an annual narrative that showed it had (a) conducted a comprehensive assessment of obstacles, and (b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility.	Noncompliance

	legislature.	• The narrative, for most of the obstacles to transition, only described the problem. Moreover, there were repeated references to numbers of individuals for whom an obstacle to transition existed, but were now placed. Thus, it was not clear how the situation was (or perhaps was not) an actual obstacle to transition. • The report did not lead to new or general strategies to address the types of obstacles to transitions for individuals who were already referred. Annual narrative by DADS state office c. The State did not present an annual narrative that showed it had (a) conducted an analysis of the Facilities' data, (b) taken 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, and (c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 6 obstacles to referral categories and 12 obstacles to transition areas used in FY13. • DADS included a list of 14 initiatives it was continuing to support. • The report included attachments with each of the Facilities' annual reports. • The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the monitoring team's reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • <u>Transition obstacles data</u>: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles). o State office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, state office staff said that their data	

		system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The monitoring team believes that this information should be included in the report. • DADS strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. o During recent discussion with state office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). o The monitoring team was unable to determine this because there was no information in the report addressing it.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose	a. The facility did provide an accurate Community Placement Report for six months ending on the week prior to the onsite review (1/1/14-7/11/14) that included the following information: • Number and names of individuals transitioned to the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference (this was an attachment that will	Substantial Compliance

	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.	need to be added to the body of this report for the next onsite review)	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a	LSSLC maintained substantial compliance with this provision item. Overall, post move monitoring was done thoroughly and competently. The PMM's reports were very detailed and were easy to read. The reports allowed the reader to have a good understanding of the status of the individual, his or her successes, identification of problems, and whether supports were being provided as per the CLDP. The reports documented the activities she engaged in, and the thorough and complete follow-up that she conducted. Providers responded and individuals were doing very well in the community. The PMM was responsive to comments and recommendations from the last onsite review and monitoring report. Since the last review, 31 post move monitorings for 15 individuals were completed. This compared with 33 post move monitorings for 15 individuals, 36 post move monitorings for 18 individuals, 22 post move monitorings for 10 individuals, and 28 post move	Substantial Compliance

	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.	monitorings for 15 individuals at the time of previous onsite reviews.
		
		The monitoring team reviewed completed documentation for all 31 post move monitorings for all 15 different individuals. Of the 31 post move monitorings, 31 were completed by the post move monitor Mary Ramsey.
		
		<u>Timeliness of Visits</u>
		For the 15 individuals, 31 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 31 required visits, 31 (100%) were conducted and 31 (100%) were completed on time. Of the 31 post move monitoring forms reviewed by the monitoring team (for 15 different individuals), all 31 (100%) included dates showing that they were completed on time (Individual #23 was hospitalized at the time of the 90-day review. The PMM conducted a visit to her provider within the required deadline and then conducted additional monitoring after the individual returned to her home).
		
		<u>Locations visited</u>
		For the 31 post move monitorings reviewed, 31 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited.
		
		<u>Content of Review Tool</u>
		31 (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 21 of the 21 (100%) 45- and 90-day visits.
		• Supports were verified, such as by indication of the evidence examined and the results of this examination, in 31 of the 31.
		  o The PMM should now provide detail in her report regarding:
		  ▪ Whether she had evidence of all aspects of required training and inservicing, such as who, what, how, and documentation of competency (rather than merely stating training documentation was reviewed).
		• Each post move monitoring report (100%) included a review of all pre move supports (as it should). The yes/no boxes were marked in each post move monitoring report.
		• There was adequate justification for findings for each support in 31 of the 31 (100%).
		• Detail/comment was included in 31 of the 31 (100%) reports for every support.	

		○ The monitoring team was very impressed with the amount of detail that the PMM provided regarding each support. She managed to do so in a succinct manner. • LAR/family satisfaction with the placement and the individual's satisfaction were explicitly stated in 31 of 31 (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 in 31 of the 31 (100%). It was at the beginning of each report. • 31 of 31 reports (65%) indicated the specific name and title of each person interviewed by the PMM. The monitoring team has the following additional comments: • The PMM had made good progress in helping providers develop and implement simple daily checklists to document the provision of many of the supports for which this type of checklist made sense to use. As discussed with the monitoring team, the checklist should not include every pre and post move support, only the ones for which the checklist was to be used (e.g., Individual #529). • The PBSP has lots of other components (e.g., interaction style, reinforcement and rewards, teaching of replacement behaviors), therefore, the PMM should be looking for evidence of implementation of these other components. This should also be addressed in the post-move support list in the CLDP. <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 who were reviewed by the monitoring team, 15 (100%) ultimately transitioned very well and appeared to be having good lives. Some of the individuals, however, experienced problems in the community (24% as described above in section T1f, metric f.). Many individuals experienced problems during their first week in their new homes. These were due to the providers failing to adequately provide the supports they had agreed to. Due to the tenacity of the PMM's post move monitoring, these were addressed and corrected. First-week problems occurred for 7 of the 10 (70%) individuals whose 7-day post move monitoring occurred since the last review. The PMM and APC should examine this issue to determine if changes to their transition planning need to occur. As discussed with the APC, a root cause type of review needs to be done for any individuals whose placements failed or who had the kinds of problems noted in T1f. <u>Use of Facility's best efforts when there are problems that can't be solved</u> In 18 of the 31 post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 13 of the 15	

		individuals. Depending upon the type of problem, the PMM worked with the provider, the LSSLC IDT, LSSLC clinical staff, and/or with the APC. Every problem was followed through to resolution. The types of problems are presented below and demonstrate the variety of topics that the PMM addressed. • Psychiatrically hospitalization • SIB protocols not being followed • Pica sweeps not being done • Psychiatrist change of psychiatric medications after one week. • Need for a PCP who can work with individuals with disabilities • Cancer on nose • Occurrence of g-tube coming out • Wheelchair seatbelt too tight, alternate seating not available, and bed motor not working • Outside exit door in the bedroom not secured/alarmed • Not attending day program • Lack of communication with public school • Not shaved properly each day • Lack of personalization of room • Infrequent outings • Personal spending money not available • Incorrect lunch food sent to day program • Bicycle still at LSSLC • New bedding not sent from LSSLC • Missing clothing <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 to be held and there were to be minutes/documentation of the meeting following post move monitorings for which an ISPA was appropriate to have been held. An ISPA meeting was necessary for 10 of these post move monitorings and was held for 10 of the 10 (100%). The PMM provided documentation showing that she notified the IDT after every post move monitoring, including sending a short summary of the post move monitoring. If she felt a meeting should be called, she called for it and it was held. For the others, she gave her opinion to the IDT (that a meeting was not necessary), but stated that she would be happy to meet with the team if the team wanted to do so.	

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.	LSSLC maintained substantial compliance with this provision. The monitoring team observed one post move monitoring, conducted at the provider office and group home of Individual #529 for the 7-day review. The PMM, Mary Ramsey, did a thorough and complete job of 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 • 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 PMM's report, completed a few days after the post move monitoring visit, was an accurate reflection of what was observed by the monitoring team. The provider was St. Giles, one of the providers that failed to provide supports for many individuals at the 7-day reviews noted above in T2a. Overall, however, this appeared to be a good placement for the individual. The staff member was very knowledgeable about the individual. The home was clean and the individual was engaged in activity.	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	Three individuals were listed as being discharged as per section T4. Thus, their discharges were required to meet this provision's discharge and transfer requirements. A sample of all 3 of these individuals was reviewed. All three were discharged via transfer to another DADS SSLC (to be closer to family, to get specialized ventilator services, under Ch.55). <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summary completed for the individuals listed above under Documents Reviewed, 3 out of 3 (100%) did contain the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. These include a summary of the individual's developmental, behavioral, social, health, and nutritional statuses. A review was conducted to determine whether or not the facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: • In 3 out of 3 records reviewed (100%), good cause was identified in the discharge summaries. • The facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies) for 3 out of 3 individuals (100%). • The facility developed a final summary of the individual's developmental, behavioral, social, health and nutritional status, and the information was adequate for 3 out of 3 individuals (100%). • For 3 out of 3 individuals (100%), the facility provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving facility. • Based on the narratives provided in the discharge reports, the report for 3 out of 3 individuals (100%) adequately described the key supports that the individual would need in the new setting.	Substantial Compliance

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o LSSLC Prioritized Need for Guardianship List o LSSLC Self-Assessment and Provision Action Information for section U o LSSLC Section U Presentation Book o Documentation of activities the facility had taken to obtain LARs or advocates for individuals o ISP, Rights Assessment (for a subsample): • Individual #402, Individual #470, Individual #170, Individual #418, Individual #526, Individual #551, Individual #410, Individual #60, and Individual #128. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Stephani Sowell, Acting QIDP Coordinator o Stephen Webb, HRO Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 7/14/14 and 7/17/14 o ISP preparation meeting for Individual #116 and Individual #163 o Annual IDT Meeting for Individual #344 and Individual #417 o Castle Pine Unit Meeting 7/15/14 o Castle Pine LOS and Protective Device Review 7/15/14 o Morning Clinical Services Meeting 7/17/14 o Executive Safety Committee Meeting 7/17/14
	Facility Self-Assessment: LSSLC submitted its self-assessment, updated on 6/11/14. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment, the results of these self-assessment activities, and a self-rating for each item. The section U audit process focused on activities that the facility had completed relevant to the consent and guardianship process. The self-assessment, however, did not assess compliance with the requirement that the facility establish an adequate assessment process for determining the need for guardianship. The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's noncompliance ratings for U1 and U2, though the ratings were not based on similar criteria.

	Summary of Monitor's Assessment: The following action had been taken in regards to section U: • The prioritized list of individuals who have been assessed to need guardians was updated. • Additional criteria were added to the assessment to determine need for guardianship, including individuals with high risk ratings and individuals with rights restrictions. • The Director of Consumer and Family Relations and the HRO continued to make presentations to community groups regarding the need for guardians and advocates. • The facility began gathering data regarding families' primary reasons for not obtaining guardianship. Cost of obtaining guardianship was identified as a barrier. The facility worked with local judges to get an agreement that the court cost for obtaining guardianship would be waived for families that identified this as a barrier. • The Guardianship Committee met to review results of the section U monitoring tool. • A representative from Disability Rights of Texas had attended the facility self-advocacy group and provided training the voting process. • The HRO continued to offer assistance with the application process for families who were considering obtaining guardianship. • The facility had an active Human Rights Committee that reviewed all restrictions. • The HRO continued to facilitate the self- advocacy group meetings. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility had not developed a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continued to need training to determine each individual's functional capacity to render informed decisions. • Provision item U2 was determined to be in noncompliance. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with provision U1 as a prerequisite. A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and	On 3/7/12, DADS State Office issued Policy #019: Guardianship. A statewide standardized assessment to determine each individual's capacity to make informed decisions was still in draft form. The state is encouraged to finalize this assessment because it should assist the facilities in moving forward with regard to the Implementation of the Section U Settlement Agreement requirements. The facility had revised the tool used to prioritize individual's need for guardianship. The tool now rated individuals based on indicators including: • Money available in individual's trust fund	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Communication skills • Level of need • Use of psychotropic medication • Number of risks categories identified by the IDT • Designated high risk ratings • Need for a Positive Behavior Support Plan • Number of rights restriction approved by the IDT While this was a good start to identifying individuals that may have priority needs, the facility needs to ensure that the IDTs engage in adequate discussion regarding whether or not the individual has the ability to give informed consent and, if not, determine if appropriate training (e.g., money management training, training on living options) or supports (e.g., communication supports) could improve the individual's ability to give consent. Two annual ISP meetings were observed, for Individual #344 and Individual #417. IDTs were not holding adequate discussions regarding each individual's ability to make informed decisions. A sample of ISPs was reviewed by the monitoring team to determine if IDTs were adequately addressing each individual's ability to give informed consent. It was not yet evident that an adequate discussion was routinely taking place at annual ISP meetings. It will be important for QIDPs to document recommendations from the assessment process and ensure that outcomes are developed to address any barriers to each individual's ability to make decisions when deemed applicable. Teams did not develop adequate training opportunities to improve decision making skills, particularly in regards to expanding each individual's knowledge of options available to them. IDTs also failed to discuss supports necessary to assist individuals in making decisions. To move forward, the facility will need to: 1. Ensure an adequate assessment process is used to determine each individual's need for guardianship. 2. Ensure that the facility's priority list for guardianship is accurate based on information gathered at annual IDT meetings.	
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	Two new guardianships had been obtained for individuals at the facility in the past six months. The Director of Consumer and Family Relations continued working with many current guardians to renew guardianship on an annual basis. The facility had some rights protections in place, including an independent assistant	Noncompliance

#	Provision	Assessment of Status	Compliance
	shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility, through the self-advocacy group at the facility Compliance with U2 will be contingent on ensuring that all individuals have been assessed using an adequate assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o LSSLC recordkeeping-related policies (no changes): • Recordkeeping Practices, Adm-15, updated 2/18/14 • Management of Protected Health Information, Adm-3, updated 2/1/13 • Policy and Procedure System, Adm-01, 11/22/13 o LSSLC organizational chart, undated but likely June 2014 o LSSLC policy lists, 7/17/14 o List of typical meetings that occurred at LSSLC, undated but likely June 2014 o LSSLC Self-Assessment, 6/30/14 o LSSLC Action Plans, 6/18/14 o LSSLC Provision Action Information, 6/18/14 o LSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/14/14 o List of all staff responsible for management of unified records, 4/28/14 o Description of flow of documents/materials (reviewed 4/29/14, no changes made) o List of other binders or books used by staff to record data (there were none) o Description of the shared drive o Tables of contents for the active records (4/24/14), individual notebooks 1/1/14, and master records (6/28/13) o Various emails, meeting notes, handouts, graphs, etc. demonstrating the URC addressing improving the unified records, and following up to problems identified in the previous monitoring report, regarding V1 and V4 o Active record check out logs in Woodland Crossing, Oak Hill, and Lone Pine units o Database of all state and facility policies, 50 pages, 7/17/14 o Database of all state and facility policies with training information, 51 pages, 7/17/14 o Database showing state policies related to Settlement Agreement sections, 14 pages, 7/17/14 o Screenshot of policy/procedure database entry page, 7/17/14 o Description of the unified record audit process o Blank unified record audit tool, 26 pages (updated 4/2/14) o List of individuals whose unified record was audited by the record clerks, January 2014 to June 2014 o Completed audits for 10 individuals (record clerk audits), April 2014 and May 2014 • Completed unified record audit and guidelines tool, • Findings list • One V4 interview of an IDT member

	• Emails showing notification of relevant staff o Set of graphs of recordkeeping department activities, 7/16/14 o Description of how the facility addressed the six aspects of V4, 5/27/14 o URCs written responses to documents found missing by the monitoring team o Active records and/or individual notebooks of: • Individual #182, Individual #310, Individual #267, Individual #262, Individual #404, Individual #16, Individual #395, Individual #163, Individual #376, Individual #211, Individual #143 o Master records of: • Individual #287, Individual #104, Individual #201, Individual #44 <u>Interviews and Meetings Held</u>: o Stormy Tullos and Terri Fatheree, Unified Records Coordinators o Shela Gibson, Program Compliance Monitor o Gale Wasson, Facility Director o Various DSP and clinical 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 URCs used the same self-assessment used during the previous review with some new additions. Thus, the suggestions provided in the previous report continued to be relevant to this 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. For V2, state and facility policies for each of the provisions of the Settlement Agreement should be separated from the other policies that are LSSLC-specific. Further, the self-assessment should include a report of the different components of the policy database that are relevant to V2 (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. This self-assessment reported on actions taken for all six items of V4 (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: LSSLC's recordkeeping department continued to manage and improve the unified records at the facility. There was good progress on all four of the items of provision V. The recordkeeping department at LSSLC maintained substantial compliance with provisions V1 and V3. Progress was seen in provisions V2 and V4. The URCs sought out and worked with various discipline heads when needed, such as nursing, behavioral health services, and habilitation. Department heads attended record clerk meetings when invited (e.g., nursing, behavioral health services). This attention to detail, follow-up, and working with the facility's many disciplines was evident in the many email chains, meeting minutes, handouts, etc. shared with the monitoring team. Fifteen of 15 (100%) individuals' records reviewed included an active record, individual notebook, and master record. The status of the active records maintained since the last review. The URCs engaged in a number of new activities to increase the likelihood of the active record maintaining substantial compliance. 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. An individual notebook existed for each individual. A master record existed for every individual at LSSLC and all were in a format that was organized and manageable. The facility now had a policy to direct policy management, a comprehensive database, and a QA staff responsible for it, thus, over the next few months the facility should update the training information and complete all training, ensure that the training data can identify not only which staff received training but also which staff still required training, update all policies that are more than one year old (as per the facility's own policy on policies), and implement a clear process for operationalizing state policies. Five (or more) reviews (audits) were conducted in each of the previous six months. Twenty-six reviews were conducted at LSSLC in the six-month period January 2014 through June 2014. They were neatly and clearly documented. Data continued to be summarized, analyzed, and used to make changes in recordkeeping practices. The URCs and data analyst continued to improve upon their set of graphs. This set of graphs adequately showed trending regarding the important data for their recordkeeping practices.

	The facility continued to address the requirements of V4 and additional progress was noted.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	LSSLC's recordkeeping department continued to manage and improve the unified records at the facility. There was good progress on all four of the items of provision V. The recordkeeping department at LSSLC maintained substantial compliance with provisions V1 and V3. Progress was seen in provisions V2 and V4. To conduct this review, the monitoring team examined aspects of the unified record for more than a dozen individuals, reviewed documents and reports, talked with various staff at the homes and day programs, and observed records in use in the program sites and during various meetings. Recordkeeping activities continued to be led by the unified record coordinators (URC) Stormy Tullos and Terri Fatheree. They were part of the QA department. 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. The URCs sought out and worked with various discipline heads when needed, such as nursing, behavioral health services, and habilitation. Department heads attended record clerk meetings when invited (e.g., nursing, behavioral health services). This attention to detail, follow-up, and working with the facility's many disciplines was evident in the many email chains, meeting minutes, handouts, etc. shared with the monitoring team. The facility maintained four of the five record clerks as during the previous review. The department, however, was somewhat plagued by absences, medical leaves, etc. Even so, the URCs and record clerks ensured that all required work was completed. 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. State policy and facility-specific policies remained the same as in previous review with the exception of one addition to the facility policy regarding the sending of original documents with individuals when they transition to the community. The active record table of contents had three changes based upon feedback from the previous monitoring report as well as changes in facility needs. The table of contents for the individual notebooks and master records remained the same.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The URCs actively participated in the facility's QA program. This included completing a monthly QA report and quarterly presentations to the QAQI Council. Fifteen of 15 (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 three of the four units at LSSLC. The URCs engaged in a number of new activities to increase the likelihood of the active record maintaining substantial compliance. • Record clerk meetings addressed the important minutiae of recordkeeping practices (e.g., asterisks on table of contents, order of documents, filing of consultations from habilitation therapy). • Implemented changes to improve the number of missing documents o by including an additional step during clerk active record reviews. o brought the data to QAQI on 3/11/14 (which resulted in additional actions by department heads). • Worked with state office to answer the question as to whether originals or copies of birth certificates and social security cards were sufficient. Originals were determined to be required. • The medical director did a presentation to medical staff regarding documentation standards. The URCs attended this session, too. • Nursing NOO attended the 2/6/14 record clerk meeting regarding the nursing section of the active record • Worked with behavioral health services director to ensure that Reiss screen information was in the active record as required. • Addressed the seizure disorder flow sheet with the physicians and diet order document with nursing. • Nursing CNE had a process to evaluate the quality of nursing IPN entries (80% were her most recent data). The following activities continued: • Continuation of audits, feedback, and follow-up, as per section V3. • Record clerks tracked the ISP for assessments 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	

#	Provision	Assessment of Status	Compliance
		the requirements of appendix D of the Settlement Agreement. The monitoring team's onsite review of active records showed approximately two to three errors/missing documents per active record. This was slightly less than what was found by the record clerks and URCs in their own audits (i.e., about four to five). 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, but was instead misfiled or attached to another document. The monitoring team's review of the active records described in sections L and M identified some areas for improvement, especially around legibility, late entries, and proper entry of verbal/telephone orders. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. An individual notebook existed for each individual. Overall, the content of the individual notebooks was appropriate and complete. Timely recording of behavior data, however, was at 50%. The multiple page set of ISP assessments were included in front of the ISP document in the individual notebooks. Some of these were more than 75 pages long. The URCs might talk with the QIDP department and with residential unit directors regarding whether these pages are necessary/useful to the DSPs. If not, they might be removed from the individual notebooks. Active treatment coordinators continued to conduct monthly maintenance reviews of the content and quality of every individual notebook. The monitoring team's review of the individual notebooks described in section M identified some additional problems with missing or out of date documents. During an observation by the monitoring team at Woodland Crossing, all of the individual notebooks were out on each individual's bed. The house manager said she was doing a check to make sure that all adaptive equipment was available as per the PNMPs that were in each individual notebook. This appeared to be a good activity. <u>Other binders/logs</u>: The facility reported that there were no other binders or logs used to record data regarding the individuals.	

#	Provision	Assessment of Status	Compliance
		Master records A master record existed for every individual at LSSLC and all were in a format that was organized and manageable. 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. Shared drive The shared drive was described to the monitoring team. The recordkeeping department reported that all information in the shared drive also appeared in hard copy in the active record and/or individual notebook. Overflow files Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Much progress was made in this section, moving the facility closer to substantial compliance. Shela Gibson managed the facility's performance for this section. It was good to see a specific QA staff member assigned to this responsibility. Not all state policies were in place yet, though continued progress was evident. State policies existed for 17 of the 20 provisions (all but G, H, and updates to U). The facility had a facility-specific policy for section G. Thus, the facility had policies in place for 18 out of 20 Sections of the Settlement Agreement (90%). Procedures for managing policies were driven by a policy "Policy and Procedure System (Adm-01)," implemented on 11/22/13. It described how policies were to be developed at the facility level and how state policies were to be handled. It also laid out how training of relevant staff was to be conducted and documented. A facility database was created to manage all of this information. It allowed for different presentations/print outs of various fields. Overall, it contained policy names, corresponding state policies and Settlement Agreement sections, dates of review, and staff training information. The database contained many more policies and updated training data than seen at the last review. Not all trainings were completed and the training information for many of the sections of the Settlement Agreement had not been updated in more than six months, and some not for more than a year.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Given that the facility now had a policy to direct policy management, a comprehensive database, and a QA staff responsible, much progress should occur over the next few months to update the training information and complete all training, ensure that the training data can identify not only which staff received training but also which staff still required training, update all policies that are more than one year old (as per the facility's own policy on policies), and implement a clear process for operationalizing state policies.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Quality assurance procedures (audits) continued in the same manner as during the last review. Further, data continued to be summarized, analyzed, and used to make changes in recordkeeping practices. The facility maintained substantial compliance with this provision. Five (or more) reviews (audits) were conducted in each of the previous six months. Twenty-six reviews were conducted at LSSLC in the six-month period January 2014 through June 2014. 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: • 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, 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). The URCs continued to do one full audit each quarter, too. This was good to see. Thus, some months had a sixth or seventh audit conducted. The URCs' data were included in the department's overall data and findings. During this six month period, however, due to staffing problems, sometimes the URC's audit was one of the five audits. This was fine and kept the facility in substantial compliance. The detailed 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 medical consultation database and the ISPs continued to be used to identify what medical consultations and SAPs should be in the active records and individual notebooks.	Substantial Compliance

#	Provision	Assessment of Status	Compliance

		The system of conducting the audit, listing all errors, emailing to the responsible person, following up on each error (with checks for corrections 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.
		
		Interobserver agreement with a QA department staff continued. The IOA database, however, was never implemented. Rather than pursuing this apparently arduous task, the monitoring team recommends that the URCs visually compare the two tools (the tool done by the record clerk and the tool done by the QA department). Then, count up the number of disagreements and report on that. Also, review any disagreements so as to improve future scores. If there are few disagreements for three months, the frequency can be reduced to once per month rather than two per month.
		
		The URCs continued to monitor differences in record clerk audit scoring. The bar graphs described in the previous report continued. These showed scorings separated by record clerk. This was a very useful and creative way to address this no-longer-a-problem topic.
		
		The URCs and data analyst continued to improve upon their set of graphs. This set of graphs adequately showed trending regarding the important data for their recordkeeping practices. Data points were graphed since January 2014 through July 2014. They should consider graphing for a longer trend period than only the last six months, especially given that they now more than a year's worth of data for some of these measures. No new graphs need to be added (other than for relevant V4 activities). Moreover, during the onsite review the monitoring team recommended that some other graphs be discontinued because they were not needed.
		• Number of audits completed each month
		• Number of errors identified each month
		  ○ 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.
		• Number of corrections made each month
		  ○ 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).
		• 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) for the total review period.	

#	Provision	Assessment of Status	Compliance

		• 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, for the review period.
		• Three bar graphs separated by record clerk:
		  o Number of errors, 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 for a second straight review period in two ways. First, upon finding that missing documents was the most frequently occurring error, they implemented interventions to address this (see V1). Second, they found that because record clerks conducted their audits early in the month, some documents not yet due were being scored as missing. As a result, the record clerks changed their audits to later in the month.	

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 taken actions since the last review and, as a result, made progress. The facility was in substantial compliance with two of the six items, #5 and #6 (33%). 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> Active records need to be available. An active record check out system was put into place to identify where a record was if it was not in the home. This, however, was not working very well, as noted in the last monitoring report. To address this, a new audit was developed, orange sign staff reminders were put in the active records area on the homes, and the ADOP sent out an email. QA PCMs were to do some checks, but this was not yet in place. The monitoring team compared the active records present with the active record sign out logs on a number of homes and found 55% of 9 record volumes that were not present	Noncompliance

#	Provision	Assessment of Status	Compliance
		were signed out correctly. In Woodland Crossing, 7 other volumes were not present, but were signed out and back in. Thus, someone looking for the missing volume could identify who likely had it, but the staff person had already signed it back in (presumably to eliminate having to do that step when returning the volumes). Data on the availability of the active records and the accuracy of the check out log is one type of information that could be collected by the facility to monitor this aspect of V4. A second type of data could be the presence/availability of individual notebooks. Record accessibility during meetings is addressed in item #6 below. This aspect of V4 was not in substantial compliance. The monitoring team also observed that: • 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 individual notebooks. Individual records were available and referenced at ISP Preparation meetings and annual ISP meetings. • Active records were available to the medical, dental, psychiatry, and pharmacy staff. • The majority of records were available to the nursing staff when needed. • Individual notebooks (which contained PBSP data sheets) were generally accessible to DSPs. • Therapy staff documented consistently related to all supports, services and interventions in the IPNs. 2. Data are filed in the record timely and accurately 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 somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews could be used to satisfy this aspect of V4, too. In addition, they might consider doing an occasional comparison of what is in the electronic shared folder (which probably contains the most recent documents) to see if what is in the active record corresponds to what is in the shared folder.	

#	Provision	Assessment of Status	Compliance
		This component of V4 was not in substantial compliance. The monitoring team also observed that: • Record clerks continued to track and monitor ISP-related documents. • Record clerks performed document transfer activities from the individual notebooks on the last calendar day of each month. • QIDP monthly reviews indicated that data on progress towards ISP outcomes was not always available for review. • Late entries by nursing were problematic. This made it especially difficult to follow the flow of events. There were many LVN and RN entries that were late by many hours. • Records were problematic for missing current Risk Ratings, Braden Skin Assessments, current physical assessments associated with an Admission/Annual/Quarterly Assessments, Hospital Liaison, ER/LTAC Nursing Assessments, and Infirmary Nursing Assessments. • Habilitation information was consistently recorded in the IPNs. • SAP data were recorded in the individual records, and appeared accurate • At both ISP meetings observed, data relevant to the risk discussion was readily available for review. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> Examples of data to satisfy this aspect of V4 include whether PBSP data, SAPs, food intake, bowel charts, trigger charts, and seizure logs are recorded up to date during the day. Active treatment coordinators were reviewing SAPs for timeliness and accuracy. Although the procedure was occurring at least since July 2013, there were no summary data, actions for improvement, or feedback system for staff and managers. The monitoring team observed that: • Data in seizure reports conflicted with IPN documentation. • For individuals who had medium or high risk, trigger sheet (e.g., aspiration, constipation) contained blanks. Trigger sheets were not consistently reviewed at the end of each shift as required. • Only 50% of data sheets reviewed by the monitoring team were recorded in a timely manner. • Data presented for review during psychiatry clinic were timely. CARLY: • The clinicians consistently documented direct therapy interventions per session. Monthly summaries were not noted consistently by the therapists.	

#	Provision	Assessment of Status	Compliance
		This component of V4 was not in substantial compliance. 4. IPNs indicate the use of the record in making these decisions (not only that there are entries made) The URCs reported a number of activities to address this aspect of V4: • The clinical services director was monitoring IPNs. Her summary data for 27 record reviews from March 2014 through July 2014 showed approximately 90% yes scores for six IPN-related items. • The medical director conducted training for medical staff in April 2014. • The medical provider audits looked at IPN entries. The round 9 audit data scores were ranged fro 50% to 100%. • Nursing department tracked nursing IPN entries and reported a compliance level of 80% • Record clerks now explained their audit ratings regarding IPN usage. This was seen in about half of the audits given to the monitoring team for April 2014 and May 2014. The item was completed, however, for all audits in June 2014 and July 2014. The comments differed in detail across clerks, as well as in what the record clerk reported she looked at. For example, some wrote about an example of an acute condition that was described in the IPN. Others wrote about discussions with nurses about how they used the active record. Thus, although there was progress in this aspect of the record audits since the last review, the record clerks need to be provided with more training and guidance regarding how to conduct this important aspect of their audits. To repeat from the last report, criteria should be specified, and findings should be summarized and reported. This component of V4 was not in substantial compliance. The monitoring team observed that: • Legibility was problematic making it difficult to use the information if it cannot be easily read. • Consult IPNs were mostly an exact copy of consult. The IPN entry should be the PCP summary and explanation. • Dental used the second column of the IPN incorrectly. • No pointer notes in the dental tab in the active records. • There was little improvement that the active record was referred to when documenting in the IPN. For example, Individual #109's record did not review historical information as to the individual's usual bowel habits, and ongoing problems of constipation, or provide an assessment of his intake and output.	

#	Provision	Assessment of Status	Compliance
		5. Staff surveyed/asked indicate how the unified record is used as per this provision item This continued, data were recorded, and responses were regularly rated at 100%. In addition, the monitoring team observed that: • The monitoring team asked nurses how they used the unified record to make clinical decisions when administering PRN medications. Responses varied, with regard to prn medications for the most part nurses reported they relied on the orders on the MAR, dates, and times a dose was last administered. • Psychiatry clinic staff were noted to utilize other information with regard to making treatment decisions (e.g., behavioral health evaluations, data graphs). This component of V4 was in substantial compliance. 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 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. It may be possible for the URCs to talk with the ISP facilitators and ask them to collect simple data for them on the presence and use of the active record during annual ISP meetings. The monitoring team found the following: • The active record and individual notebook was present at the ISP for Individual #417. The record was opened when needed. • The active record and individual notebook were present at the CLDP meeting for Individual #526. The records were not needed or accessed during the meeting. • The QIDP facilitator provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #551 and Individual #410. Data from assessments were entered into these two forms so that team members could reference current assessments when developing necessary supports. The record was available at the meeting and was used by the team when additional information was needed. • The active records were present for each individual who was seen in the wound clinic. All of the records were referred to for assessments, physician orders, and reviewing associated completed diagnostic tests. For example, for Individual	

#	Provision	Assessment of Status	Compliance
		#586, the Nurse Practitioner and wound clinic team reviewed the individual's historical data regarding his circulatory status and his series of diagnostic Doppler tests when making treatment decisions and referral to PT. • Active records and individual notebooks were present and available at psychiatry clinics. • Active records were not available during the PNMT meeting, but the RN and other clinicians had conducted a record review prior to the meeting in order to report various elements of the individual's current status. • Active records were not brought to pneumonia review committee, but should have been. This component of V4 was in substantial compliance.	

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
ADS	Annual Dental Summary
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AHA	American Heart Association
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
BHS	Behavioral Health Services
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
CI	Clinical Intervention
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
NHLBI	National Heart, Lung, and Blood Institute
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
PD	Program Developer
PDD	Pervasive Developmental Disorder
PDR	Physicians Desk Reference
PECS	Picture Exchange Communication System
PEG	Percutaneous Endoscopic Gastrostomy
PEMA	Psychiatric Emergency Medication Administration
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
POC	Polypharmacy Oversight Committee
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
RBBB	Right Bundle Brach Block
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
RPO	Rights Protection Officer
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