United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of On-Site Review: April 19-23, 2010

Date of Report: June 25, 2010

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I. Background - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement (SA) covers 12 State Supported Living Centers, 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 (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement, the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him or her every six months, and detailing his or her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of the Lufkin State Supported Living Center (LSSLC).

In order to conduct reviews of each of the areas of the Settlement Agreement and Healthcare Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this baseline review of Lufkin SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, treatments and supports, and consent;

Karen Green McGowan reviewed nursing care and dental services; Pamela Wright-Etter reviewed psychiatry services, medical care, and pharmacy and safe medication practices; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programming; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, record keeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 SA.

II. 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 April 19 through April 23, 2010, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(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. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports, and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint

documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

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

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

III. 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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;

(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;

(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. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. It is in the State's discretion, however, to adopt a recommendation or use other mechanisms to implement and achieve compliance with the terms of the SA.

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. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

First, the monitoring team wishes to acknowledge the outstanding cooperation and responsiveness of all staff members at all levels at LSSLC. A review, such as this, is impossible without the willingness of management, clinicians, and direct care professionals to provide the team with a variety of information. Throughout the week of the on-site tour, LSSLC staff assisted monitoring team members with scheduling meetings, interviews, and observations; obtaining documents and reports; getting around campus; and answering a myriad of questions. Further, this required many LSSLC staff to re-arrange their schedules, transport team members around the facility, include team members in meetings, participate in interviews, and allow themselves to be observed conducting their typical job activities. The monitoring team also acknowledges the willingness of many individuals to talk about their lives at LSSLC and to be observed in their daily day, work, and home activities. The monitoring team also appreciated the efforts of Nikki Yost, Settlement Agreement Coordinator, and Sherry Roark, Administrative Assistant, for their availability and assistance throughout the entire week of the onsite tour.

The facility director, Gale Wasson, set the tone for the onsite tour during the opening meeting on the first day of the tour. She invited the monitoring team to learn everything possible about LSSLC and she instructed all of her staff to be open and to answer all questions posted to them by team members. This collaborative approach was right in line with the way the parties intended for the monitoring process to occur.

As a result, a great deal of information was obtained during this tour as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding more than 100 individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Second, the monitoring team found management, clinical, and direct care professionals eager to learn and to improve upon what they do each day to support the individuals at LSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong on-site tour. Although it is difficult to provide much technical assistance during a baseline tour, team members found opportunities to share ideas and make suggestions. Their comments were well received. The team hopes to continue to provide suggestions and recommendations and has done so throughout this report.

Third, below some general themes found by the monitoring team are discussed.

Settlement Agreement

- All of the senior administrators and managers at LSSLC were aware of the Settlement Agreement and that it had many provisions. These senior leaders, however, were at the early stages of fully understanding the contents of each provision of the Settlement Agreement and only appeared to have a general appreciation of the breadth and depth of content within each provision. A thorough understanding of each provision and the many items within each provision will be required for the facility leadership to provide guidance and support to its middle managers and staff. Moreover, many of the senior administrators and managers had direct responsibility for one or more areas. As they become more knowledgeable and fluent in their ability to discuss provision items, so too will their staff.

Caring Practices

- The monitoring team observed many examples of caring practices at LSSLC and was impressed by the level of care provided to a population of individuals who had a variety of complex and multiple needs, including many who required total care and many who needed around the clock treatment for fragile medical conditions. In addition, numerous caring and pleasant interactions were observed between individuals and direct care professional staff. LSSLC was fortunate to have many staff, at all levels, who had worked at the facility for many years. It was not uncommon to speak with a house manager or administrator who had more than 20 years experience at the facility. The monitoring team met the parents of some of the individuals. These parents reported a high degree of satisfaction with the care that their daughter received. Many of the residences at LSSLC, however, were crowded. LSSLC should consider ways of ensuring that residences are populated in a manner that allows for individuals to have sufficient personal space and sufficient common space.

Integration of Services

- Throughout this report, there are comments regarding a need to improve the integration of services. That is, that teams need to ensure that information from various sources, including, but not limited to, assessments and evaluations, data from previous goals and objectives, the preferences and strengths of the individual, knowledge of staff and family members about the individual, and so forth is synthesized into a plan that comprehensively addresses the individual's preferences, personal goals, and needs. At the same time, facility management needs to ensure that there is no marginalization of any professional discipline, that is, that all disciplines have the opportunity to participate and contribute to the service provided. The monitoring team was pleased that some positive steps were taken with the medical and psychiatry staff during the week of the onsite tour.

Competency-Based Training

- LSSLC had an organized system for staff training that followed the state's policy and procedure regarding type of job, level of contact with individuals, and core and specialized trainings. Each of these trainings was tied to a

state centralized curriculum, training content, materials, and documentation system. The facility's Director of Competency Training and Development, Kendra Carroll, had more than 10 years experience in this role and her department appeared to be well organized. Staff, however, received lots of other trainings that were not part of the centralized system, such as training on PBSPs, PNMPs, dining plans, and so forth. These are trainings that are typically designed for specific individuals and the trainings occur by therapists and clinicians at the residences and day program sites. There did not seem to be an organized way for the facility to track and manage the provision, competence, and follow up for these types of trainings.

Educational Services

- A number of individuals lived at LSSLC who were under age 22 and therefore were entitled to educational services. At LSSLC, this was the responsibility of the local school district, Lufkin Independent School District. LSSLC staff reported that there was an excellent relationship between LSSLC and LISD and that most of the students attended school in LISD school buildings off campus for at least part of the day. During the onsite tour, however, the monitoring team learned that some individuals attended school for a minimal number of hours each day, some did not leave campus at all and received inadequate educational services, and the content of IEPs did not reflect the needs of some of the students. The monitoring team wishes to support the ongoing positive relationship between the facility and the school district, but at the same time wants to ensure that every student gets the educational services to which he or she is entitled for this relatively brief period in his or her life. This is discussed in more detail below in this report, in section S.

Immediate Attention

- Throughout the report to follow, many details and examples are provided that identify positive practices that were occurring at the facility as well as a variety of areas that were in need of attention and improvement. Some of these areas required more immediate attention to ensure that individuals were not at any risk of harm. Some of these areas of service were as follows:
    - the assignment of proper risk levels to individuals,
    - proper positioning during meal times,
    - presentation of proper food textures, size, and pacing,
    - medication management systems,
    - ensuring that all required supports are in place prior to transition to the community and during all post-move monitoring visits.

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

Restraints

- There was a decrease in restraints from FY08 to FY09. Trend reports attributed the decrease to the psychology department implementing restraint reduction procedures when it became evident that these would be statewide expectations. An action plan was implemented following FY09 to reduce the number of restraints at the facility. Efforts appeared to be successful based on the significant reduction in restraints use at the facility. In order to have a clear picture of where restraint reduction efforts need to continue, the facility should develop a system to collect data on restraint use by individual, staff involved, date, and time, and analyze those data to identify trends. Trends were not available regarding the use of medical and dental restraints at the facility. The facility had a restraint reduction committee in place. The committee discussed the need for better data collection to be able to trend restraint use. Even so, there was concern from the monitoring team in regards to the lack of an interdisciplinary approach to addressing restraint reduction at the facility. It was not clear that all team members contributed information regarding what interventions had been tried to reduce restraints and had input regarding the effectiveness of those interventions. It was also not evident that intervention strategies were carried out consistently enough to know if they were effective or not. Team members from all disciplines need to coordinate efforts to address behavioral issues. A review of documentation of restraint incidents indicated that a majority of restraints were not documented and monitored in compliance with the facility policies. Details are summarized in this report, in section C.

Abuse, Neglect, and Incident Management

- LSSLC had policies in place to address identifying, reporting, and investigating incidents of abuse, neglect, and exploitation. All staff interviewed were familiar with the policies and had received training consistent with facility policies. There was a system in place for completing internal investigations and referring investigations to DFPS, local law enforcement, OIG, and DADS Regulatory, however, there appeared to be some inconsistencies in determining which entity was to take the lead in criminal investigations.

Quality Assurance

- LSSLC had a newly appointed Director of Quality Enhancement, and a staff of program compliance monitors that was energetic and dedicated to providing quality enhancement services. The facility did not yet have a quality enhancement plan at LSSLC that was organized, systematic, meaningful, functional, or useful to administrators, managers, clinicians, or staff. Nevertheless, numerous QE-related activities were occurring at LSSLC, including the observation and monitoring of various areas by program compliance monitors. These were developed and

implemented without any facility guidance or direction. Instead, they were developed by program compliance monitors. Data were maintained by the program compliance monitors, but not integrated into any facility QE report, or reviewed in any organized manner by facility administration or at the facility's Performance Improvement Council meetings. It is expected that the quality enhancement program will develop and mature over the next few years at LSSLC. The monitoring team looks forward to continued development of LSSLC's quality assurance program.

Integrated Protections, Services, Treatment, and Support

- The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items in this provision were either not developed or not yet implemented thoroughly enough to allow for monitoring. The state policy was still in draft format. The development of person centered plans was a clear focus of the facility PSTs and the quality assurance team; they were aware of areas that needed to be addressed to improve the person centered planning process. As evidenced by PSPs reviewed, the facility had made some progress towards developing person centered plans for individuals served at the facility in the past year. The plans clearly showed an effort to gather information on the individual's needed supports, interests, preferences, and long-term goals. Although much of this information was included in the plans and discussed by the team at PSP meetings, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision. Outcomes should reflect plans that provide supports necessary to help each individual achieve his or her individualized vision. The overall goal of each plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the individual's plan.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- The need for the integration of clinical care was evident at LSSLC and comments regarding this are noted throughout this report. The state was in the process of developing policies to guide the facility in meeting these provisions of the Settlement Agreement. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate.

At-Risk Individuals

- There was consensus among staff at the facility that contributing factors to challenging behaviors at the facility were staffing ratios, overcrowded homes, and grouping of individuals with challenging behaviors. The facility did not have a plan in place to address any of these factors. Risk statements in PSPs were general and often conflicted with information included in the PSP by specific disciplines. Problems with the content and

implementation of state policy regarding the assessment and assigning of risk level is noted in numerous sections of this report. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual.

Psychiatric Care and Services

- State and facility policies in psychiatry to address this provision of the settlement agreement were in development. Overall, at LSSLC there was fragmentation of psychiatric services and psychiatric services were not integrated into the overall clinical set of services and supports provided to individuals. Individuals at LSSLC who received psychotropic medication had not been evaluated and diagnosed in a clinically justifiable manner. Of the sample of records reviewed, only one individual had a fully detailed psychiatric evaluation conducted by a qualified psychiatrist as outlined in Appendix B of the Settlement Agreement. Further, there were a number of individuals who had one or more psychiatric diagnoses and were not receiving psychotropic medication despite having diagnoses that usually required such medication. There were no psychiatric treatment plans in place (other than a listing of medications the individual was receiving and any relevant target behaviors) and there were no quarterly reviews of the records reviewed that specified timelines for the expected therapeutic effects to occur. Lab values were dictated into the quarterly psychiatry reviews, however, there were some reviews that did not contain the pertinent lab tests and, in some cases, the abnormal lab was noted, but there was no attempt to explain the abnormal number. There was also difficulty with coordinating medications that may overlap with neurology. None of the records reviewed had any evidence of integration of behavioral interventions with pharmacological treatments and the psychiatrists did not participate in formulation or updates of a PBSP. Further, psychiatry was not involved with monitoring or assessing pre-treatment sedation strategies for routine medical care.

Psychological Care and Services

- LSSLC had begun to address many of the items in this provision of the Settlement Agreement. Nevertheless, there were several areas that required additional attention and improvement. These included improvements in data collection and presentation, functional assessments, and Positive Behavior Support Plans (PBSPs). Further work needed to be done to include all of the aspects of programming for behavior disorders within the PBSP, including the use of positive contingencies. Additionally, the psychology department was without several critical behavioral systems, such as inter-rater agreement of data, measures that monitored and ensured that PBSPs were implemented with integrity, and a peer review system. Many individuals did not have psychological assessments, and many more had assessments that were more than 20 years old. The facility needs to develop a plan to ensure that all individuals have a current, accurate, and complete psychological assessment. The monitoring team believes that those writing and monitoring PBSPs need to receive the training, supervision, and experience associated with board certification as a behavior analyst (BCBA).

Medical Care

- The DADS central office was developing more policies and procedures in order for the medical department to be able to meet the Settlement Agreement provisions. The LSSLC physicians had a strong attitude of care and concern for the individuals at LSSLC. This was evident in many ways, such as in the amount of time and amount of presence they had at the facility. The facility maintained a busy infirmary onsite where individuals that needed more medical monitoring were able to have round the clock nursing care. Each primary care physician at the facility had a separate caseload for which he was responsible. This included providing the preventative and "sick call" care for each individual. Each physician monitored his own labs, x-rays, EKGs, and outside consults. The current medical director worked on numerous flow sheets for various commonly occurring conditions. Numerous recommendations are listed in this report below, in section L.

Nursing Care

- Many positive aspects of nursing care were observed at LSSLC, including the recent addition of the Chief Nurse Executive and the addition of new nursing FTEs. New systems were being put into place, including those to meet the requirements of the Settlement Agreement. Nursing assessments were generally adequate, though there were problems with the DAP system of recording (as noted below in section M) and with documenting to resolution. Issues for the nursing department included providing a regular head to toe assessment when there is acute illness, adequately assigning risk levels to individuals, and providing comprehensive nursing care and treatment for typical, but important, conditions seen in this population, such as GERD and respiratory problems. Also, the administration and management of medications were fraught with problems, including the manner in which medications were stored, the creation of MARs, and the number of medication errors.

Pharmacy Services and Safe Medication Practices

- The facility had hired a director of pharmacy services and a Doctor of Pharmacology only within the two months prior to this onsite baseline tour. As a result, activities were occurring to assess and understand the needs at the facility and the requirements of the Settlement Agreement. For example, the system of medication management included the use of Zip Lock bags and tackle boxes, one of the many practices to which the new managers need to attend, evaluate, and correct. It is hoped that the pharmacy department will become a more integrated part of the service provision at LSSLC as required by the Settlement Agreement.

Physical and Nutritional Management

- LSSLC had a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. The systems intended to assign and manage risk issues, however, were not coordinated and integrated; instead they functioned in a parallel manner. Assignment of risk did not consider thresholds and

outcomes related to recommendations and interventions. For example, a number of individuals were listed at medium or low risk for aspiration, choking, osteoporosis, and skin breakdown when, in fact, they had actual diagnoses in these areas. Further, PNMPs were not consistently and properly implemented, staff training was not competency-based, and monitoring did not occur with sufficient frequency to ensure that staff compliance was routine. The dining rooms in some homes were large and the atmosphere was chaotic, not at all conducive to a safe and pleasant mealtime environment aside from the fact that it complicated adequate supervision and supports for staff and for the individuals for whom they were responsible. New employees were observed providing assistance and supervision to individuals at mealtimes with no supervision, coaching, or monitoring by supervisors.

Physical and Occupational Therapy

- The OT and PT staff were dedicated and striving to provide appropriate services. Insufficient PT staff, however, competed with their ability to get every individual services in a timely and thorough manner. A great deal of staff training will be required, in particular, in relation to implementation of the PNMP for every individual. Multiple errors in position and alignment were observed. Improvement must also be made in the facility's internal monitoring. PNMP Coordinators required more training in what it was they were monitoring, and more direct supervision.

Dental Services

- Dental services at MSSLC were at the beginning stages of improvement. A lot of progress had been made in recent months in the provision of routine dental care. Further, appropriate use of intravenous anesthesia was being made available to individuals for whom this level of intervention was necessary.

Communication

- LSSLC had dedicated speech and language therapists and technicians, however, the department was woefully understaffed and it was unlikely that the current staff would be able to meet the requirements of this Settlement Agreement provision. Overall, however, evaluation updates were thorough and included important information about the individual's communication style and needs. Additional consideration should be given to making assessments more efficient so that they do not needlessly take up the limited time of therapists. Across the facility, there was very little use of augmentative and alternative communication devices; many additional individuals would likely benefit from these types of devices. Further, the support and training of communication skills was not integrated into the daily life of the individuals. Collaboration and integration with the psychology department may lead to better training programs for individuals so that communication skills might be learned, generalized across the individual's day, and maintained over time.

Habilitation, Training, Education, and Skill Acquisition Programs

- Skill acquisition programs existed for most individuals and were being implemented to varying degrees. The quality of these instructional plans, however, needed much improvement. The plans needed to incorporate more evidence-based instructional procedures that have been shown to be effective in improving the skills of people with developmental disabilities, including the use of positive reinforcement, shaping, prompting, and collection of data. Only one individual was employed in the community, and little, if any, skill training occurred in community settings. Engagement of individuals in activities was observed by the monitoring team. Varying levels of engagement and participation were found. This was another area recommended for focus on at the facility, including the regular collection of data, feedback to managers, and training of staff. The educational services for individuals who were under age 22 and still entitled to a public education was being supported by the facility, however, LSSLC must ensure that every individual entitled to educational services receives those services in a manner that is appropriate for their educational needs.

Most Integrated Setting Practices

- LSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. Overall, however, very few individuals were in the referral process. An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various PSPs and documents at the facility. LSSLC conducted a number of educational activities and participated in regular meetings with local MRAs. The facility also had the opportunity to add to the content of the self-advocacy groups to include community placement, decision-making, and problem solving as regular topics for discussion. The facility's QMRPs were preparing for updated training regarding the living options discussion of the annual PSP meeting. The facility had two experienced staff recently appointed to positions to address this provision of the Settlement Agreement. They had responsibility for the CLDP and post-move monitoring processes. CLDPs were reviewed for all individuals who had transitioned this past year. The list of essential and nonessential supports in these CLDPs were not individualized and did not include all of the important supports that the individual would likely need to be successful. Post-move monitoring was occurring as required. More detailed descriptions of how to determine the presence or absence of a support are required if the monitoring is to be meaningful.

Consent

- LSSLC was beginning to address the requirements of this Settlement Agreement provision. A newly disseminated DADS policy was being used to guide the facility in identifying and prioritizing those in need of guardianship, and in seeking out appropriate individuals to serve as guardians. A Guardianship Coordinator had been appointed

Recordkeeping and General Plan Implementation

- LSSLC was preparing to implement new procedures in accordance with the new DADS policy. A recently revised table of contents for each individual's active record had also recently been finalized. New materials (e.g., binders, dividers) had been ordered. The facility was fortunate to have three Unified Records Coordinators who were experienced with the recordkeeping system at LSSLC.

The comments in this executive summary were meant to highlight some of the more salient aspects of this baseline review of LSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team looks forward to continuing to work with DADS, DOJ, and LSSLC.

Thank you for the opportunity to present this report.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management o DADS Policy #001: Use of Restraint o Restraint Checklist Form 4012008R o Administration of Chemical Restraint Form o LSSLC Policy: Restraint Implementation for Nursing Procedures Revised 07/09 o LSSLC Policy: Restraint Implementation Procedures 7/03/09 o Restraint Data and Trends FY08-FY10 o Restraint Analysis for last ten restraints o Log of all restraints 7/1/09-3/22/10 o Injury from Restraint Log 07/09-03/10 o Sample of restraint debriefing forms o Human Rights Committee Meeting Summaries from 9/09-02/10 o Restraint Reduction Team Quarterly Meeting Notes 3/25/10 and 12/30/09 o Chemical restraint documentation for three individuals o Physical restraint documentation for five individuals o List of individuals with safety plans Daily Incident Review Team Meeting Summaries for the following time periods: • 11/2/09-11/6/09 • 1/4/10-1/8/10 • 2/8/10-2/12/10 • 2/16/10-2/20/10 • 2/22/10-2/24/10 • 3/1/10-3/5/10 o Training transcripts and background checks for • Seven Direct Support Professionals o Sample of PSPs including: • Individual #57 11/18/09 • Individual #136 2/16/0910 • Individual #169 3/5/10 o Restraint Summary for • Individual #124 Interviews and Meetings Held:

	o Informal interviews with various staff in homes and day programs throughout campus o Interview with Stacie Cearley, Program Compliance Monitor o Vernon Wiggins, MA, Associate Psychologist III o Ranleigh McAdams, MA, Associate Psychologist III <u>Observations Conducted</u>: o Hidden Forest Morning Unit Meeting 4/20/10 o Oak Hill Morning Unit Meeting 4/22/10 o Daily Incident Management Meeting 4/20/10 and 4/22/10 o Human Right Committee Meeting 3/23/10 o Annual PST meetings for Individual #332 and Individual #524 o Residences 520, 523, 529 524, 542, 549, 550, 557, 559, 561, 563, and 643 o Large Workshop o Small Workshop
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Restraint data were provided to the monitoring team from FY08-FY10 (1st half). There were a total of 56 emergency and programmatic restraints for FY09. For the first half of FY10, there had been 25 restraints in these two categories, indicating a slight decrease. The decrease was reflected in the number of programmatic restraints with a slight increase in emergency restraints. The facility had restraint data trended by individual, type of restraint, location of restraint, when the restraint occurred, and outcome of the restraint. Trend summaries categorized the restraint type as programmatic or emergency restraint. It was not, however, clear as to what types of restraints were included in each category of restraints. For example, it was unknown if chemical restraint administered for behavioral intervention was included in emergency or medical restraint data. Similarly, it was unknown which type of restraints were included in the programmatic restraint category. In the quarter prior to the review, there had been 14 behavioral related restraints, including six for self injurious behavior, four for aggression towards staff, and four for aggression to peers. The restraints involved six individuals. Of the last 14 documented restraints for crisis intervention included in trend reports, three were chemical, two were hand holds, one was an arm hold, three were bear hugs, one was a basket hold, and four were horizontal holds. Six of the eleven restraints were on the same individual; three of these were horizontal holds. It was noted that mechanical restraints had been used at least 12 times for Individual #488 since July 2009.

	This number was not included in facility trend reports for restraints used for crisis intervention. Documentation through August 2009 indicated that the restraints were used in response to aggression. After August 2009, documentation indicated restraints were used in response to self injurious behavior. It was not clear why these incidents were not included in restraint data, since this would be considered crisis intervention. There was a significant decrease in restraints from 676 in FY08 to 186 in FY09 (this number also includes medical-related restraints). The trend reports attributed the decrease to the "Chief Psychologist implementing restraint reduction procedures when it became evident that these would be statewide expectations." An action plan was implemented following FY09 to reduce the number of restraints at the facility. Efforts appeared to be successful based on the significant reduction in restraints use at the facility. In order to have a clear picture of where restraint reduction efforts need to continue, the facility should develop a system to analyze and identify trends. Reduction efforts need to focus on any obvious trends and strategies that may prevent behavioral situations from escalating in specific situations. Trends were not available regarding the use of medical and dental restraints at the facility. The facility should trend that restraint data also and develop plans to reduce the use of medical and dental restraints to the extent feasible. The facility had a restraint reduction committee in place. This committee met 3/25/10 to review restraints for the first two quarters of FY10. The committee discussed the need for better data collection to be able to trend restraint use. There was concern from the monitoring team in regards to the lack of an interdisciplinary approach to addressing restraint reduction at the facility. It was not clear that all team members contributed information regarding what interventions had been tried to reduce restraints and had input regarding the effectiveness of those interventions. It was also not evident that intervention strategies were carried out consistently enough to know if they were effective or not. Team members from all disciplines need to coordinate efforts to address behavioral issues. A review of documentation of restraint incidents indicated that a majority of restraints were not documented and monitored in compliance with the facility policies. Details are summarized in the following sections of this report.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if	Assessment of this item required review of policies and an examination of implementation of those policies. State and facility policies existed to address the provisions of the Settlement Agreement regarding restraints. The state policy was labeled "Use of Restraints," numbered 001, and dated 8/31/09. It included five addenda guidelines and forms. The facility policy addressing restraints was titled Restraint Implementation Procedures and dated 7/03/09. It too contained addenda forms to be used in the	

#	Provision	Assessment of Status	Compliance
	the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	documentation of restraints. The use of prone and supine restraint was prohibited by the policy. In addition, the use of mechanical restraints other than approved protective restraints had been discontinued by the facility according to interviews, though the facility policy still allowed the use of mechanical restraint for crisis intervention. There was no evidence that prone or supine restraints were in use at the facility. Staff interviewed were aware of the mandates prohibiting the use of prone and supine restraints. The facility policy prohibited the use of restraint for disciplinary purposes, retaliation, and retribution, for the convenience of staff or other individuals, and as a substitute for effective treatment or habilitation. Policies mandated that restraints may only be used in acute emergencies that placed the individual or others at serious threat of violence or injury and only after less restrictive measures had been determined to be ineffective or not feasible. The policy outlined when and how restraints were to be used and described procedures that staff must follow regarding monitoring and documentation of restraint use. These policies were in line with the contents of this provision. All Restraint Checklists reviewed indicated that the individual was at risk of harming self or others. In all cases, verbal prompts and/or redirection was attempted prior to the use of restraints. The effectiveness of behavior support strategies is discussed in other sections of this report. As indicated in the summary section above, there was evidence that mechanical restraints were still in use for behavioral intervention. This included the use of a helmet and wristlets for at least one individual, both were approved types of mechanical restraints in facility policy. Documentation of the use of mechanical restraints for Individual #488 on 2/3/10 did not indicate that a range of least restrictive measures had been attempted prior to the application of mechanical restraint. The psychologist for Individual #124 had utilized an innovative procedure to fade the time the individual was in arm restraint. The procedure consisted of a large ring installed on the side of Individual #124's wheelchair. The device did not restrain his arm or prevent him from voluntarily moving his arm in and out of it. It did, however, substantially reduce the time that Individual #124's arm was restrained. Individual #124 often voluntarily moved his arm in the ring rather than hitting himself. In February of 2010, Individual #124 was restrained for an average of four hours a day. In contrast, at the time of the on-site tour he was in restraint for an average of 40 minutes a day. The other two individuals with protective equipment wore helmets to prevent injury from head hitting/banging. Individual #460 had a fading program, and was faded to 15 minutes in the helmet and 45 minutes out of the helmet each waking hour at the time of	

#	Provision	Assessment of Status	Compliance
		the on-site tour. The other individual with protective equipment, Individual #192, was in her helmet 55 of every 60 minutes. Even so, the psychologist continued to implement several interventions (e.g., pairing out-of-helmet time with positive reinforcers) to attempt to fade the use of the helmet.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The facility policy mandated that restraints be terminated as quickly as possible and as soon as the individual was calm and no longer a danger to self or others. Restraints were only allowable for a duration of 30 consecutive minutes (excluding protective mechanical restraint). The last five physical restraints were reviewed. None of the five reviewed lasted over ten minutes. Restraint checklist and Restraint Debriefing, Review, and Face-to-Face Assessments completed for each incident of restraint indicated that restraints were terminated as soon as the individual was no longer a danger to himself, herself, or others.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Prevention and Management of Aggressive Behavior (PMAB) was used at all facilities across the state and was the specific training program identified in the state and facility policy. The policy described the types of restraints that were allowed to be used and listed restraint types that were specifically prohibited. There was no evidence that any prohibited restraints had been used during the period reviewed. Staff were required to complete initial training and were retrained at least annually on the use of restraints. This training included RES0105 Restraint: Prevention and Rules for Use of Restraints at MR Facilities, RES0110 Applying Restraint Devices, and Competency Based PMAB training. Training transcripts were reviewed for seven employees and confirmed that all seven had completed all three training modules within the past 12 months. A larger sample of employee training records will be reviewed in upcoming monitoring visits. Informal interviews with staff confirmed a basic knowledge of policies regarding restraint, including prohibited restraints and required documentation and follow-up. When direct care professional staff were questioned about what they do if an individual begins engaging in aggressive behavior, direct care staff were able to describe a limited number of strategies or redirection approaches to managing the behavior. Staff reported that they were comfortable in seeking additional information from psychology staff assigned to their work area and, furthermore, staff indicated that psychology support staff was readily available and helpful when they needed additional support. It was observed during the on-site review that psychology staff were on the floor, available, and involved with individuals and their direct care professional staff. Direct care professional staff indicated that campus auxiliary staff was available during	

#	Provision	Assessment of Status	Compliance
		evening and weekend hours and responded quickly to provide back up support if a behavioral crisis occurred.	
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.	The facility policy stated that restraints may only be used for crisis intervention or medical reasons. There was no indication that restraints had been used at the facility other than for crisis intervention or medical reasons. As required, safety plans were in place to guide staff in using restraints for crisis intervention for those individuals where restraints had been used three or more times in any 30 day period. The facility had a Restraint Reduction Team that met quarterly. The team reviewed restraint trends and developed restraint reduction objectives for the facility. The team developed objectives in December 2009 and continued those same objectives in March 2010 to reduce the number of monthly restraints by a specific percentage. There were no plans developed to guide the facility in reducing the percentage of restraints, though the minutes stated that the objectives had been met for both quarters. The minutes also stated that the facility "will continue to direct efforts towards overall reduction of restraint use as well as minimizing the level of restrictiveness when applied." Again, there was no indication of how this goal would be accomplished. The Restraint Reduction Team should use data collected by the facility to make recommendations on reducing restraint in specific areas and develop outcomes and action plans for reducing restraints in those areas. A list of medical and dental restraints used from July 2009 through February 2010 indicated that dental restraints had been used with 79 individuals during that time period. Thirty-four of the individuals (43%) had dental desensitization plans in place. Medical restraints had been used with 77 individuals. Twelve of those individuals (16%) had medical desensitization plans in place. It was unknown from the data, how many of these restraints included pre-treatment sedation for surgical procedures. • Individual #136 was on the list of individuals having had dental sedation with no desensitization plan in place. Her PSP stated that she was sedated for routine dental cleaning, but there was no indication that the team had considered a dental desensitization plan. • Individual #169, however, did have a dental desensitization plan in place. The plan contained very limited strategies for desensitization, including two action steps: 1) will come to the dental clinic building and sit in reception area for a few minutes, and 2) will come into the dental clinic and when asked will sit in the visitor's chair for a few minutes. There was no indication that this would be attempted more frequently than at her annual dental visit. The use of medical and dental restraints will be reviewed further during upcoming monitoring visits.	

#	Provision	Assessment of Status	Compliance
		A PST meeting was observed for Individual #557 during the review week. Chemical restraints were approved for use during dental procedures. A desensitization plan was in place to try to reduce the use of restraints during dental procedures. The facility had a Human Rights Committee (HRC) that met weekly. The committee reviewed restraint incidents, as well as other rights restrictions. HRC meeting minutes reflected that not all restraint applications were routinely approved by the committee, for example, the committee did not approve the use of medical or dental restraints for Individual #551 on 2/10/10 or for Individual #144 on 2/24/10. There is not a summary of discussion in the meeting minutes, so it was unknown why the HRC denied approval.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the	The facility policy mandated monitoring of restraints by a health care professional within the guidelines of this provision. Restraints were to be monitored with a face-to-face assessment of individuals within 15 minutes of the application of any restraint. Staff were required to complete a Restraint Debriefing, Review, and Face-to-Face form for each incident of restraint applied for crisis intervention. The policy, additionally, addressed monitoring of individuals following restraints applied away from the facility with provisions of this agreement. Policy mandates met this provision of the Settlement Agreement. There were no documented incidents of restraints applied away from the facility in the last six months. A sample of the last eight Restraint Debriefing, Review, and Face-to-Face forms were reviewed by the monitoring team. This was 57% of the restraints utilized in the quarter prior to the onsite review week. Of the eight forms reviewed, three of the forms (38%) indicated that the health care professional did not document the vital signs or mental status of the individual as required, or a reason why the vital signs or mental status were not assessed (e.g., brevity of restraint). Five of the last eight Restraint Checklists reviewed included an attempt by the nurse to assess the individual for vital signs and mental status following the restraint incident. Documentation did not reflect that the facility policy regarding monitoring by a health care professional was followed in three of the five incidents. Details of those incidents are summarized below. In total, six of the eight restraints (75%) were not monitored as required. • Restraint documentation for Individual #488 dated 2/3/10 indicated that the first attempt by the nurse to check blood pressure was at 1:20 pm though the form indicates the restraint was not initiated until 1:28 pm. A second attempt was not made until 4:45 pm and was also refused.	

#	Provision	Assessment of Status	Compliance
	individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	• Restraint documentation for Individual #176 dated 3/11/2010 indicated that the individual refused assessment. The time of attempted assessment was not recorded. The nurse note stated the individual was breathing with difficulty. A second attempt to check vital signs was not indicated. • Documentation for Individual #105 dated 2/19/10 indicated that the nurse did not assess the individual until 40 minutes after the start of the restraint. The facility needs to ensure that a health care professional does a face-to-face assessment of each individual as soon as possible following release from restraints. When an individual refuses assessment, the health care professional should attempt another assessment after allowing the individual time to calm.	
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.	The facility had a Restraint Checklist and Face-to-Face Assessment, Debriefing, and Review checklist for use when restraint was applied for crisis intervention. This form included a check for restraint related injuries. Facility policy addressed safety and supervision during restraint. This policy met the standards of this provision. One-to-one supervision during physical restraint and following medical or chemical restraints was documented in all incidents reviewed. There was only one reported injury to an individual during restraint use in the eight restraint incidents reviewed. This was a non-serious injury. Restraint related injuries were reviewed by nursing staff and documented. Documentation indicated that individuals received continuous one-to-one supervision during restraint usage.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three	The facility policy addressed this section of the Settlement Agreement requiring the Personal Support Team (PST) to develop and implement a Behavior Support Plan and a Safety Plan for Crisis Intervention for any individual placed in restraint, other than medical/dental restraint, more than three times in any 30 day period. Additionally, the	

#	Provision	Assessment of Status	Compliance
	times in any rolling thirty day period, the individual's treatment team shall:	PST was required to review restraints and document items C7.a – C7.g in a Personal Support Plan Addendum. According to a list provided to the monitoring team, there were seven individuals with safety plans in place at the time of the monitoring visit. Individual #57 had four documented physical restraints for aggression between 2/7/10 and 2/21/10. He did not have a safety plan in place, but did have a BSP. His PST met the day following each of the restraint incidents to review the use of restraint. A PSP addendum documented each of the meetings. At each of the meetings, the team recommended continuing to follow his BSP and review his medications. There did not appear to be discussion regarding revising his BSP to try to develop more effective strategies for managing his aggression in a less restrictive manner. The adequacy of the assessment process for any individuals who have been placed in restraint more than three times in any rolling 30 day period will be reviewed during upcoming monitoring visits. Informal interviews with direct care professionals and review of restraint documentation and Positive Behavior Support Plans revealed that staff did not have adequate strategies in place to ensure that restraints would only be used as a last resort intervention. The adequacy of Behavioral Assessments, Positive Behavioral Support Plans, and Crisis Intervention Plans is addressed elsewhere in this report. The facility will need to focus on behavioral assessments and recommendations to effectively reduce the number of restraints used for crisis intervention.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	See note C7 above.	
	(b) review possibly contributing environmental conditions;	See note C7 above.	
	(c) review or perform structural assessments of the behavior provoking restraints;	See note C7 above.	
	(d) review or perform functional assessments of the behavior provoking restraints;	See note C7 above.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the	See note C7 above. See section K for additional comments on PBSPs.	

#	Provision	Assessment of Status	Compliance
	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;		
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	See note C7 above.	
	(g) as necessary, assess and revise the PBSP.	See note C7 above.	
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 policy mandated that a review of each restraint, other than medical and dental restraint, would occur within three business days of the restraint based on the Restraint Checklist, the Restraint Debriefing Report, and, as applicable, the Chemical Restraint Consult form. The Restraint Checklist had a place to indicate review by the Restraint Monitor and Psychologist and a place to document the Unit Review date. The following is a summary of the review that occurred for each of the eight restraints assessed by the monitoring team. There was no evidence that one of the eight was reviewed by the restraint monitor, three did not indicate review by the psychologist, and three did not indicate review by the unit.	

#	Provision	Assessment of Status	Compliance

Individual/Restraint Type	Date	Reviewed by Restraint Monitor	Reviewed by Psychologist	Reviewed by Unit
#488/Mechanical	2/3/10	2/3/10	2/3/10	No evidence
#600/ Bear Hug	2/16/10	2/16/10	No evidence	No evidence
#203/Physical hold	2/17/10	2/17/10	No evidence	No evidence
#105/Physical hold	2/19/10	2/19/10	2/22/10	2/22/10
#176/Chemical	3/11/10	3/11/10	No evidence	3/12/10
#176/Bear Hug	3/11/10	3/11/10	3/11/10	3/12/10
#269/Bear Hug	3/8/10	3/8/10	3/9/10	3/9/10
#147/Chemical	3/16/10	No evidence	4/17/09	4/12/09

Restraints that had occurred the prior day were reviewed at Daily Incident Management meetings observed during the onsite review week. The team reviewed each restraint and discussed possible contributing factors to the behavior. The team reviewed trends to see if individuals restrained had been restrained three or more times in a rolling 30 day period. A review of Incident Management Review Team (IMRT) Minutes indicated that the IMRT reviewed all incidents of restraint during the meeting following the incident.

The facility had quality assurance procedures in place to monitor the use of restraints (but see section E of this report). At the time of the monitoring visit, a Restraint Analysis Checklist had been completed on each restraint incident. A compliance score was given for each incident based on whether or not facility policy had been followed. Restraint analysis documentation for 10 restraints was reviewed during the monitoring visit. Only five (50%) of the incidents received a compliance score of 85% or greater. Documentation and monitoring of restraint use were the primary areas indicated to be in need of improvement in review of restraint incidents. This was in line with findings of the monitoring team as indicated in this report.

Recommendations:

1. Complete behavioral assessments as often as needed to determine precipitating factors to restraint use and develop Positive Behavior Support Plans that offer direct care professionals a graduated range of less restrictive interventions to manage behaviors in the least restrictive manner.

2. Psychology staff should provide individual specific training to staff on strategies for behavioral intervention and request frequent feedback from staff on which strategies are effective. Plans should be reviewed and modified when strategies are not effective in deescalating aggressive or self-injurious behavior.

3. The Restraint Reduction Team should use data collected by the facility to make recommendations on reducing restraint in specific areas and develop outcomes and action plans for reducing restraints in those areas.

4. Continue to focus on developing desensitization programs for individuals currently using medical and dental restraints and develop written plans to support consistent implementation of desensitization efforts.

5. The facility needs to ensure that a health care professional does a face- to- face assessment of each individual as soon as possible following release from restraints. When an individual refuses assessment, the health care professional should attempt another assessment after allowing the individual to calm down.

6. The facility needs to develop clear guidelines for classifying each type of restraint and ensure that facility trends reflect each type of restraint used.

7. All disciplines need to work together to identify behavioral interventions that may reduce the use of restraints and ensure that interventions are consistently used.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	

Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:**
	
	<u>Documents Reviewed</u>:
	o State Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management
	o Unusual Incident Report Coding and Reporting Matrix
	o LSSLC Policy: Client Management – Investigation of Client Abuse/Neglect/Exploitation 11/20/09
	o LSSLC Policy: Reporting, Documenting, and Review of Unusual Incidents 3/18/09
	o LSSLC Competency Training – Abuse & Neglect 11/20/09
	o LSSLC Policy Directive regarding the placement of staff on temporary work assignment, due to an allegation of A/N/E
	o LSSLC Incident Management Map (Reporting Matrix)
	o LSSLC Policy: Injuries to Individuals 9/28/09
	o LSSLC Policy: Individual Supervision 6/12/09
	o LSSLC Investigator List
	o Fall Assessment Form
	o LSSLC Investigative Report Form for Injuries Related to Behavior Interventions
	o Discovered Injury/Abuse/Neglect Monitoring Tool
	o Injury Report Flow Chart
	o LSSLC Procedure: Performance Improvement Council 11/1/08
	o LSSLC Procedure: Safety and Health Team
	o LSSLC Procedure: Administrative Morning Meeting Council
	o Abuse and Neglect ABU0100 Training Curriculum
	o QE Review Observation Note Monitoring Summary March 2010
	o List of all abuse/neglect/exploitation investigations 7/1/09/09 – 3/18/10
	o Log of Client Injuries 7/1/09 – 3/26/10
	o Client Injury Reports for three most recent injuries resulting from peer-to-peer aggression.
	o LOS Log for week of 4/20/10
	o Level of Supervision log for serious incidents 7/09-2/10
	o DFPS Five-Day Status Report for three investigations
	• Human Rights Committee Meeting Summaries from 9/09-02/10
	• Quality Enhancement Review: Observation Note Monitoring Summary March 2010
	• Proof of background check for seven Direct Support Professionals
	• Training for :
	  • Seven Direct Support Professionals
	  • Michael Ramsey, Lead Investigator
	  • Kathy Thompson, QE Director
	  • Stacie Cearley, Program Compliance Monitor

	• Keith Bailey, Investigator • Lisa Curington, Investigator • Barbara Draper, Investigator • Kenneth Garcia, Investigator • Royce Garrett, Director of Individual & Family Relations • Nikki Yost, Settlement Agreement Coordinator • Glenn Heath, Investigator • Gail Husband, Assistant Director of Programs • Lucy Logan, Investigator • Todd Miller, Investigator • Bonnie O'Quinn, Investigator • Kenneth Self, Investigator • Rotley Tankersley, Investigator • Michael Thigpen, Investigator • Brenda Vansickle, Investigator • Gale Wasson, Director o Sample of PSPs including: • Individual #57 11/18/09 • Individual #136 2/19/09 • Individual #136 2/16/0910 o Daily Incident Review Team Meeting Summaries for the following time periods: • 11/2/09-11/6/09 • 1/4/10-1/8/10 • 2/8/10-2/12/10 • 2/16/10-2/20/10 • 2/22/10-2/24/10 • 3/1/10-3/5/10 o Sample of Unusual Incident Reports including: • #113 3/19/10 • #100 2/18/10 • #99 2/18/10 • #117 3/25/10 • #121 4/3/10 o Sample of Closed DFPS Investigative Reports from 11/09-3/10 (26 total) • #34987351 1/24/10 Exploitation Referred back to facility • #34768949 1/4/10 Emotional/Verbal Abuse Unconfirmed • #34790632 1/5/10 Neglect Inconclusive • #34807210 1/6/10 Physical Abuse Inconclusive • #34830189 1/8/10 Physical Abuse Unfounded • #34837449 1/9/10 Physical Abuse Unconfirmed

	• #34873529 1/13/10 Neglect Unconfirmed • #34922601 1/18/10 Neglect Unconfirmed • #34913510 1/15/10 Emotional/Verbal Abuse/ Physical Abuse Unconfirmed • #35065472 2/1/20 Neglect Unconfirmed • #35154869 2/7/10 Physical Abuse Unconfirmed • #35151889 2/6/10 Physical Abuse Unconfirmed • #35148630 2/5/10 Physical Abuse Unconfirmed • #35090989 2/2/10 Physical Abuse Unconfirmed • #35035089 1/27/10 Physical Abuse Unconfirmed • #35024229 1/2710 Neglect Inconclusive • #34999909 1/25/09 Emotional/Verbal Abuse Unconfirmed • #34113629 11/15/09 Physical Abuse Confirmed • #35575869 3/15/10 Emotional/Verb Abuse Physical Abuse Unfounded • #35483530 3/7/10 Neglect Unfounded • #35484010 3/7/10 Physical Abuse Unconfirmed • #35462570 3/4/10 Emotional/Verb Abuse Physical Abuse Unfounded • #35438849 3/3/10 Physical Abuse Unconfirmed • #35394069 2/27/10 Physical Abuse Unconfirmed • #35304411 2/21/10 Neglect Inconclusive • #35180049 2/9/10 Neglect/ Physical Abuse Unconfirmed <u>Interviews and Meetings Held</u>: o Stacie Cearley, Program Compliance Monitor o Michael Ramsey, Lead Investigator o Kathy Thompson, Quality Enhancement Director o Royce Garrett, Director of Individual and Family Relations o Valerie, QMRP o Keith Bailey, Hidden Forest Unit Director o Four Direct Support Professionals o Informal interviews with DCPs, QMRPs, Unit Directors, and Psychology Staff <u>Observations Conducted</u>: o Hidden Forest Morning Unit Meeting 4/20/10 o Oak Hill Morning Unit Meeting 4/22/10 o Daily Incident Management Meeting 4/20/10 and 4/22/10 o Human Right Committee Meeting 3/23/10 o Annual PST meetings for Individual #332 and Individual #524 o Residences 520, 523, 529 524, 542, 549, 550, 557, 559, 561, 563, and 643 o Large Workshop o Small Workshop

	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: LSSLC had policies in place to address identifying, reporting, and investigating incidents of abuse, neglect, and exploitation. All staff interviewed were familiar with the policies and had received training consistent with facility policies. Information regarding identifying and reporting abuse and neglect was posted in each building in the facility. There was a system in place for completing internal investigations and referring investigations to DFPS, local law enforcement, OIG, and DADS Regulatory. The local DFPS office had recently employed several new investigators. There was discussion at the facility Incident Management Meeting regarding the lack of consistency in DFPS investigations. There were two abuse incidents reviewed where DFPS investigation findings were inconclusive while OIG found evidence of criminal activity in the investigation. The facility investigator was working with DFPS to try to correct the inconsistencies and provide support to new investigators. This was working relationship was good to see. Further, the facility investigators reported having a good relationship with DFPS, local law enforcement, and OIG. The facility trended unusual incidents including injuries, choking incidents, deaths, and allegations of abuse and neglect. Data were trended by individual, home, shift, day of the week, and injury/incident type. There were a total of 1152 injuries involving 299 individuals from 12/1/09 through 2/28/10. Seventeen of those injuries were serious injuries; 728 were non-serious, but required treatment; and 407 required no treatment. Thirty of these injuries involved abuse or neglect allegations. The top three causes of injuries were scratches, slips/trips/falls, and bumping into something. FY10 1st quarter trend analysis for allegations of abuse and neglect was reviewed. There were 30 cases of abuse or neglect reported to DFPS during the 1st quarter of FY10. This was a 28% decrease from the previous quarter. It was a slight increase from the 29 allegations reported during the same quarter of FY09. Of the 30 cases, three were confirmed as neglect, 20 were unconfirmed by DFPS, two were unfounded by DFPS, one was referred back to the facility, three allegations were inconclusive, and one investigation had not been completed. There were no confirmed cases of abuse during the three months reviewed. Twenty four administrative employees at the facility had completed investigator training that included the courses Conducting Serious Incident Investigations (CSI1000) and Fundamentals of Investigations – Labor Relations Alternatives (INV0100). Informal interviews with some of the investigators confirmed that they were familiar with agency policies on investigation procedures and consistent in their approach to incident management. It did not appear, however, that DFPS, OIG, and local law enforcement handled all investigations consistently. The monitoring team has been informed that DADS was working on clarifying this issue in the near future.

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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.	Assessment of this item required review of policies and an examination of implementation of those policies. The state policy was labeled "Protection from Harm-Abuse, Neglect, and Incident Management." It was numbered 002.1, and was dated 11/6/09. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and staff reporting. The facility had policies in place titled Investigation of Client Abuse/Neglect/Exploitation dated 11/20/09 and Reporting, Documenting, and Review of Unusual Incidents dated 3/18/09. The policy regarding Client Abuse and Neglect clearly indicated that abuse and neglect of individuals would not be tolerated and required staff to report any abuse or neglect of individuals. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted in each facility visited and all staff interviewed were able to relay this information.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility	The facility policy specified reporting requirements for all serious incidents and was in line with this provision. The facility policy included a reporting matrix that served as a quick reference for determining to whom incidents should be reported, and within what time frame. The facility utilized a standardized reporting form for all serious injuries and incidents. All incidents reviewed documented notification to the Facility Director as required. Policies mandated that all incidences of suspected abuse, neglect, or exploitation were to be reported to DFPS within one hour. A review of investigation documentation confirmed that the facility was generally in compliance with this mandate, although, there were exceptions as noted in D.2.d below. There were posters at each facility site that provided basic instructions on intervening to stop abuse, as well as reporting abuse. The 1-800 number to call to report suspected	

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	Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	abuse was posted on bulletin boards and near phones around the facility.	
	(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 policy mandated immediate action and reporting of all allegations of abuse and neglect. Initial staff in-service training included training on recognizing and reporting incidents of abuse and neglect (Course ABU0100) that was to be provided upon initial hire and annually for tenured staff. Staff interviews confirmed that staff were aware of the mandate to immediately protect the victim from further harm. Further, facility staff appeared to take immediate and appropriate action to protect individuals involved. Observation of facility Incident Management Meetings confirmed that participants discussed each incident and made recommendations to further protect the individual if warranted by removing alleged perpetrators, increasing staffing ratios, or requesting other additional supports as needed. The facility had a policy addressing the reassigning of alleged perpetrators. It was evident that alleged perpetrators were routinely reassigned until investigations were completed. A log of staff reassigned during investigations from 7/1/09 through 3/25/10 indicated that staff were removed from positions providing direct support to individuals and reassigned to jobs in food service, personnel services, records, and maintenance. Staff were not returned to regular duties until DFPS notified the facility that the allegations were not confirmed. A log of disciplinary action from 7/09 showed that the facility disciplined perpetrators in the two cases where abuse and neglect were confirmed. In the one case of neglect, the employee was counseled, and in the one case of confirmed abuse, the employee was dismissed. A log of 32 serious incidents at the facility from 7/09 through 2/10, that included allegations of abuse and neglect and serious injuries, showed that 24 of the individuals were placed on enhanced supervision and eight were placed on one-to-one supervision.	
	(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 facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation. Documentation of training was kept by the facility and a small sample was reviewed. Training transcripts for the employees interviewed showed that all had received required training on abuse and neglect within the past year. During interviews, all employees were able to give accurate examples of abuse and neglect and verbalized their responsibility for reporting such incidents. A larger sample	

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		of training records will be reviewed for compliance of this provision item during future monitoring visits.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The policy addressed mandatory reporters. All staff who were interviewed were aware of their obligation to report. A sample of staff personnel records was not reviewed during this initial review to verify the existence of these signed statements regarding reporting obligations, however, this will be verified during future reviews. In all facility buildings toured during the review, posters stating the obligations of mandatory reporters were posted in common areas. Even so, a review of investigations at the facility revealed that staff suspecting abuse did not always report the abuse as required. • In DFPS investigations #35035089 dated 1/27/10, a direct support professional claimed to have witnessed physical abuse of an individual by a coworkers on 1/22/10, but did not file a report until 1/27/10. Additionally, according to the DFPS investigation report, she did not cooperate in the investigation by allowing the DFPS investigator to interview her during the investigation. • In DFPS investigation #34999909 dated 1/25/10, an employee filed a report with DFPS alleging abuse, which she stated she witnessed on 1/21/10. She waited until the following Monday to discuss it with her supervisor before filing the report. Information received by the monitoring team indicated that the employee in the first case above resigned from the facility after being non-cooperative with the investigation. The employee in the second case above was a new and waited four days to report the information to her supervisor. She received counseling discipline. The facility appeared to address reporting mandates with these two employees for failing to report suspected abuse or neglect within required time frames. It was unclear, however, why the new employee, who would have recently received training in this area, made the decision to wait to file a report.	
	(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	The policy stated that a training and resource guide on recognizing and reporting abuse and neglect will be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. Clear reporting information was posted in each building in the facility. A review of abuse and neglect investigations indicated that at least some of the individuals and their LARs were aware of reporting procedures and had reported	

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	who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	suspected abuse and neglect incidents to DFPS.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	All facility buildings toured had posters with a statement of individuals' rights called "You Have the Right" posted in common areas. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The facility policy stated "Abuse or neglect of an individual by LSSLC is prohibited and shall be grounds for appropriate action, to include reporting of the incident to law enforcement authorities." It further required "the DFPS investigator will report abuse-related allegations of a criminal nature to the law enforcement agency with local jurisdiction unless a written agreement for an alternate reporting mechanism is in place or they will notify the Director/Designee if they do not intend to report to law enforcement within one hour." The facility Lead Investigator was assigned to coordinate investigations with law enforcement and OIG Investigators. DADS needs to work with OIG and local law enforcement agencies to determine which entity will take the lead in criminal investigations and ensure that all reported incidents of criminal activity are followed up on and investigated in a consistent manner.	
	(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.	Policies prohibited retaliatory action for reports of an allegation of abuse or neglect. The policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect, and mistreatment should be reported. The FY10 1st quarter trend analysis report stated that there had been a systematic action plan put into place to trend false allegations for individuals and staff which included PBSPs to address spurious allegations and, in the case of staff making false allegations to DFPS, the facility planned to take corrective punitive measures up to termination. The facility needs to ensure that these measures do not make staff hesitant to report any incidents of suspected abuse or neglect for fear of disciplinary action if, in fact, the allegation is unconfirmed.	

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	During the onsite monitoring visit, it was found that not all injuries were reported and documented consistently at the facility. It was difficult to track information regarding current injuries. In one obvious injury noticed by the monitoring team, there was no documentation regarding the cause of injury and staff on duty had not made any effort to identify the cause of injury. When notified of the injury, the Unit Director thoroughly investigated the injury and found the cause. Documentation was put into place regarding the incident and a memo was sent to staff reminding them to report and document all injuries of unknown cause. In another case where the monitoring team noted an injury on an individual, documentation was available, but not easily found. The facility needs to ensure that staff have information readily available regarding injuries, so that they can be reported appropriately if the cause has not been determined and so that staff will know when to seek medical care. The quality enhancement department monitored observation notes for compliance with facility policies, procedures, and reporting requirements relating to documentation of all injury types, with a focus on information related to incidents that would require the completion of an Unusual Incident Investigation form. QE Program Auditors reviewed a minimum of one observation note per unit monthly for compliance. Overall compliance in this area for March 2010 was at 50% according to a summary of monitoring. This is a beneficial process for identifying systematic issues in reporting and documenting injuries. A review of documentation of serious injuries supported that they were routinely reported for investigation. According to the facility investigators, all serious injuries were investigated by the facility investigators and then referred to DFPS or DADS as required. This will be reviewed further during upcoming monitoring visits.	
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		

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	policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The state policy addressed the conduct of investigations and qualifications of investigators. The policy stated that all investigators who were responsible for completing all or part of the Unusual Incident Report must complete the course, Comprehensive Investigator Training (CIT0100) within one month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report. Additionally, the Incident Management Coordinator and Primary Investigator(s) must complete the Labor Relations Alternative's (LRA) Fundamentals of Investigations training (INV0100) within six months of employment. There were 24 trained investigators on staff at LSSLC, this included all Unit Directors. A review of the training transcript for all investigators revealed that each had completed the state required trainings. Having numerous trained investigators on campus ensured that investigations could begin promptly.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The facility policy mandated that staff were required to cooperate with DFPS and law enforcement agencies in conducting investigations. An interview with the facility investigator, and review of a sample of completed investigations indicated investigations were a cooperative effort with DFPS investigators. The lead facility investigator was interviewed and was able to describe incident types and the process for reporting to DFPS, OIG, local law enforcement, and DADS regulatory.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	It was evident in documentation that the facility investigators completed preliminary steps to ensure the safety of the individual (e.g., medical evaluations and removing APs), and then allowed appropriate entities to complete investigations as necessary. The facility investigator stated that the facility had a good working relationship with local law enforcement agencies and OIG and worked cooperatively with them. There was no evidence that this was not the case.	
	(d) Provide for the safeguarding of evidence.	The facility policy described procedures for safeguarding evidence in the event of a serious incident. Some DFPS investigations were not completed in a timely manner (see below) leading to questions of whether or not investigators were able to gather all evidence while it was still available.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident	The policy addressed timelines for investigations. The state policy required that investigations commence within 24 hours, but allowed for investigations to be completed within 14 days (10 days after June 1, 2010). All investigations handled by facility investigators commenced within 24 hours of notification and were completed within 10 days of the incident. Investigations by DFPS	

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	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.	commenced within 24 hours of notification for all incidents reviewed, but were not always completed within 10 days. A sample of 15 DFPS investigations reviewed for timeliness revealed the following: • Six (40%) of the investigations in the sample were completed by the 10th day, • Three (20%) were completed within 15 days, and • The remaining six (40%) were completed between 16 and 29 days following the report. It was noted that extensions were filed for all six incidents completed after 15 days. All investigations reviewed included a summary of the investigation and findings. Most reports did not include recommendations for corrective action.	
	(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	The policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. Investigation files were consistently compiled in a clear and easy to follow format. Investigation reports did not include a list of previous related allegations.	

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	perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.		
	(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.	A review of five investigations completed by the facility investigators indicated that final investigations were reviewed in the Daily Incident Review Meeting and by the Incident Management Coordinator and Facility Director. DFPS investigation reports were signed by the investigator. It was unclear if supervisory staff at DFPS reviewed the investigations to ensure they were thorough, complete, accurate, and coherent. Given concerns by the facility regarding the thoroughness of DFPS investigations, the facility should work with supervisors at DFPS to ensure that investigations contain all required elements. This will be reviewed further during upcoming monitoring visits. According to an interview with the Lead Investigator at LSSLC, completed DFPS investigations were reviewed at the Daily Incident Review Meeting. It was noted at the Daily Incident Review Meeting observed during the onsite monitoring visit, that the team reviewed recently completed DFPS reports and, in one case, asked for additional information and further investigation before approving the release of the AP back to work in a direct support position even though the finding was unconfirmed.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A sample of Unusual Incident Investigation forms was reviewed by the monitoring team. Each written report was written in a clear and consistent manner. Reports included an in depth summary of investigative procedures, relevant history, personal information about the individual, a list of immediate corrective actions to be taken, and an analysis of findings and recommendations for remedial action to be taken.	
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	It was evident that the facility followed up on individual incidents by immediately removing APs from contact with individuals, taking disciplinary action when warranted, and holding PST meetings to review incidents and take corrective action as needed. Action taken in each case was documented by the facility on the Unusual Incident Investigation form. Corrective action was discussed and reviewed at daily incident management meetings. The facility maintained a log of APs reassigned during investigations. APs were assigned to positions within the facility that required no contact with individuals served at the facility during investigations. They were not released to return to their previous position until DFPS completed their investigation. In two cases reviewed by the Daily Incident	

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		Review Team during the week of the monitoring visit, DFPS had closed the case with the finding of inconclusive. OIG found criminal activity in both cases. The Incident Review Team requested that DFPS investigate further before a decision was made as to disciplinary action for the employees involved. A review of Unusual Incident Reports, level of supervision logs and PSP addendums documented that there was usually a level of supervision increase, immediately and at least temporarily, for individuals involved in any type of unusual incident. The increased level of supervision remained in place until either the PST or the incident management committee recommended a return to routine supervision.	
	(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.	A review of investigation records from the past year confirmed that files were maintained and were easily accessible for review. DFPS investigations did not include a log of previous related incidents.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. Incidents and allegations were trended by individual, home, location, date and time, staff involved, cause and incident type. The Incident Management Committee should review not only current incidents occurring at the facility, but also review trends for system issues that the facility may need to address with a plan of correction. Falls were found to be in the top three causes of injuries at the facility, but there was no plan in place to address fall prevention as a systemic issue.	
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	Criminal background checks were reviewed for four current employees. Background checks were in place for all four employees. These appeared to be routine for newly hired staff. Employees were also required to complete a form disclosing all arrests, indictments, and convictions immediately upon employment. A sample of this form was not reviewed. Additional review of this system for both employees and volunteers will occur during future monitoring visits.	

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	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.		

Recommendations:

1. The state needs to collaborate with OIG and local law enforcement agencies to determine which entity will take the lead in criminal investigations and ensure that all reported incidents of criminal activity are followed up on and investigated in a consistent manner.

2. DADS should address the trend of lengthy delays in DFPS completing investigations with the local DFPS agency.

3. Implement an audit process to determine whether or not significant injuries were reported for investigation.

4. Data gathered on incident and injury trends should be analyzed and a summary of findings should be used to develop specific objectives in the facility's quality improvement/quality enhancement plan.

5. Ensure all individuals and their LARs receive the annually required information regarding abuse and neglect.

6. Continue to monitor DFPS investigations for thoroughness of investigations and work with the DFPS supervisor to correct inconsistencies in investigations.

7. Request a list of all relevant incidents for each individual and perpetrators to be included in DFPS investigation reports.

8. The facility needs to ensure that staff have information readily available regarding injuries to individuals so that they can make a quick determination when needed to file a report or seek medical care.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003: Quality Enhancement, dated 11/13/09 o LSSLC policy list, dated 4/2/10 o LSSLC policy and procedure manual o Organizational chart, dated 3/18/10 o Quality Enhancement Plan 4/18/10, updated 4/21/10 o LSSLC Quality Enhancement Processes, dated 1/5/10 o LSSLC policy: Performance Improvement Council, Committee and Councils-16, dated 11/1/08 o PIC meeting notes: monthly July 2009 through February 2010 o List of meetings scheduled 4/19/10 through 4/23/10 o Incident Management review team meeting notes/log, 4/21/10 o LSSLC plan of improvement, 8/09, updated 2/5/10 o LSSLC set of blank audit tools • Seven tools related to health care: Acute care plan, change in health status, G-tubes, health management plan, MAR, medication administration, quarterly and annual nursing assessments • Monitor's checklists for Sections T1, T4, and U • Two pages labeled as related to Section F • One page labeled as related to Section S • Four pages related to psychiatric care • Four pages related to psychological care • One page regarding restraint • Two pages related to behavior plans • Two pages reviewing DCP observation notes • Two pages labeled as an analysis of restraint • One page labeled "Injury Prevention Columbus POC" • Five pages of questions for a staff interview • Three pages regarding communication and Section R • Seven pages regarding Sections O and P • Eight pages labeled as a PNMP monitoring tool o Data, tables, and reports that were required by DADS central office: • employee injury data from July 2009 through January 2010 • client injury data June 2009 through Dec 2009 • quarterly trend analysis (1st quarter FY10, September 2009 through December 2009: ▪ unusual incidents ▪ abuse and neglect allegations ▪ injuries, and

	▪ restraints o Tools, forms, reports, and notes created and submitted by LSSLC QE staff: • Active Treatment Home Observation Monitoring Tool • Acute Care Plan Audit, January, February, March 2010 • Health Management Plan Audit • Sedation Audit • Comments about a review of DCP Observation Notes • Review of 34 restraint reviews, from 4/09 through 1/10 • Various emails commenting about PNMP-related observations o Oak Hill/Castle Pines Self-Advocacy Meeting agenda <u>Interviews and Meetings Held</u>: o Kathy Thompson, Director of Quality Enhancement o Nikki Yost, Settlement Agreement Coordinator o QE Department Program Monitors: • Tabitha Anastasi, Elizabeth Canley, Stacie Cearley, Gena Hanner, Marvin Stewart, Stephen Webb o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o All residences and day programs o Self-advocacy meeting
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: LSSLC had a staff of program compliance monitors that was energetic and dedicated to providing quality enhancement services that met the generally accepted professional standard in this area as defined in the Settlement Agreement. The Director of Quality Enhancement was relatively new to the position and had a variety of other responsibilities. The Settlement Agreement Coordinator provided oversight of some aspects of quality enhancement. LSSLC, however, did not have a quality enhancement plan at LSSLC that was organized, systematic, meaningful, functional, or useful to administrators, managers, clinicians, or staff. Nevertheless, numerous QE-related activities were occurring at LSSLC, including the observation and monitoring of various areas by program compliance monitors. These were developed and implemented without any facility guidance or direction. Instead, they were developed by program compliance monitors. Data were maintained by the

	program compliance monitors, but not integrated into any facility QE report, or reviewed in any organized manner by facility administration or at the facility's Performance Improvement Council meetings. It is expected that the quality enhancement program will develop and mature over the next few years at LSSLC. Improvements and developments will be needed in the breadth of the quality enhancement activities, the validity and reliability of the department's data collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality enhancement report. Other comments are detailed below in this section of the report. The monitoring team looks forward to continued development of LSSLC's quality assurance program.

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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.	A review of this section of the Settlement Agreement required the monitoring team to look at policy, processes, and outcomes related to quality assurance activities at LSSLC (these are referred to as quality enhancement (QE) in this report). A policy was developed by the state DADS regarding quality assurance titled "Quality Enhancement." It was labeled policy #003 and was dated 11/13/09. The facility had adopted this policy in full. The policy called for a quality assurance system that, if implemented, would meet the requirements of this provision of the Settlement Agreement. The policy had a number of addenda and forms that were to be used for the Quality Enhancement plan, corrective action plans, tracking of these plans, and operation of the performance improvement council. LSSLC, however, was not implementing or following the components of this policy at the time of the on-site monitoring tour. It did not have a comprehensive, organized, or systematic quality enhancement process in place. There were, however, a number of quality enhancement-related activities going on at the facility. Nevertheless, as a result of the absence of any quality assurance system or quality enhancement plan, there was little upon which the monitoring team could comment. The monitoring team expects to see a more formal and comprehensive quality assurance and quality enhancement program initiated and in place at LSSLC when it returns for the next on-site tour. <u>Policies</u> The Director of Quality Enhancement told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility. Little activity, however, had occurred at LSSLC to implement the policy. In addition, at LSSLC, there were no policies or processes related to quality enhancement that were specific to the facility. Only one document was presented to the monitoring team. It was titled "LSSLC Quality Enhancement Processes," was dated 1/5/10, and	

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		provided a description of the processes the facility was to use, but was not specific to LSSLC. It appeared to be a general description of quality enhancement that was written by DADS central office. Moreover, very little, if anything, had been done at LSSLC towards addressing the contents of this document. <u>Quality Enhancement Plan</u> The DADS policy required the development of a quality enhancement plan (QE Plan). A meaningful QE plan did not exist at LSSLC. The Director of Quality Enhancement, however, had completed the QE Plan form that was part of the state policy. It was dated 4/18/10, that is, it was completed immediately prior to the initiation of this on-site tour. After discussion with the monitoring team, the QE Plan form was revised during the tour and a new one was presented dated 4/21/10. It merely listed a row for each of the SA provisions (c through v) plus some rows for other types of data required by DADS central office or in response to DADS regulatory investigations and surveys. Columns referenced the Settlement Agreement or state or federal regulations, the primary person responsible for that section, the frequency with which monitoring was to occur, the tools to be used, the sample size, and what reports to use. Overall, this was not a useful, active document that provided any guidance to anyone at the facility, such as QE staff, unit managers, or facility administrators. This QE plan was insufficient, did not reflect generally accepted professional standards as defined in the Settlement Agreement, and did not follow the policy. It was not developed in a manner consistent with the policy or with generally accepted professional standards in the field of quality assurance. Development of an acceptable QE plan requires working with all of the facility's disciplines, its management staff, its senior administration, and with members of the QE department staff in order to identify important outcomes, measurement systems, and reporting mechanisms that are both valid and reliable. <u>QE Department</u> Kathy Thompson was the director of the QE department. She had been in this role for approximately one year after working for one year as a QMRP at LSSLC. Prior to working at LSSLC, she had many years of experience in quality enhancement at another state agency. In addition to supervising the QE staff, she supervised the facility's lead investigator, campus administrators, the unified records coordinator, and the training director. The Facility Director should assess whether this is reasonable given the needs of the quality enhancement program at LSSLC. Nikki Yost, the Settlement Agreement Coordinator, also played a role in quality enhancement activities. She began working in this position in October 2009 and had	

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		only returned from an extended leave two weeks prior to the on-site monitoring tour. Prior to becoming Settlement Agreement Coordinator, she had worked in the QE department for one year and, before that, had worked for many years for a community provider of residential services. Both the Director of Quality Enhancement and the Settlement Agreement Coordinator appeared to be new to LSSLC facility operations, QE processes, and the requirements of this provision of the Settlement Agreement. They will both need support from facility senior administration and from DADS central office if LSSLC is to have an effective quality enhancement program that meets the requirements of this provision (provision E) of the Settlement Agreement. The Director of Quality Enhancement and the Settlement Agreement Coordinator reported directly to the Facility Director. This was a good organizational structure for LSSLC given the amount of work needed in quality enhancement. It sets the occasion for full integration of the QE department, SA activities, and quality enhancement into the overall operation of the facility. The QE department had six FTEs devoted to QE activities (not including the director), including the addition of a new employee during the week of the on-site tour. In addition, Ms. Yost had an assistant, Sherry Roark, who provided clerical and organizational support to the activities required of the Settlement Agreement Coordinator, including activities that occurred before, during, and following the on-site tour. LSSLC was fortunate to have a team of engaging and dedicated QE staff who were called Program Compliance Monitors (PCM). The monitoring team met with them as a group and learned about their specific activities (described below), concerns, and goals. The PCMs were operating without much guidance and leadership. Overall, they wanted to conduct themselves professionally and to have their work be meaningful. As would not be unexpected, without leadership and direction, they determined what to monitor on their own, created their own forms, implemented data collection and sampling on their own, and developed reporting mechanisms individually (e.g., reports, emails). Some of these activities appeared to be thorough and to be implemented consistently, whereas others appeared less organized and consistent. PCMs would benefit from additional training in quality assurance and quality enhancement. Although they described themselves as a very new team that worked well together, it appeared that they did not meet regularly and had little opportunity to discuss systems and context issues related to their work. The PCMs also reported a range of response to their activities at LSSLC from a good response to their feedback (e.g., habilitation therapies) to no change or response (e.g.,	

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		nursing services). Overall, strong leadership and direction will be required from the QE Director and from the Facility Director in order to make QE functional and meaningful to all managers, clinicians, and staff at LSSLC. Only when QE activities are seen as helpful, does QE becomes more valued at a facility. <u>QE Activities</u> To reiterate, numerous QE activities were occurring at LSSLC even though a coordinated, comprehensive QE plan was not in place. Some of these activities are listed below. Overall, some important and useful information was being collected. The absence of a QE plan, however, resulted in the activities being fragmented, isolated, and, to a large extent, appearing to be random in their selection, design, application, and usefulness. • Activities conducted by QE program compliance monitors: as noted above, the PCMs created a number of forms, tools, and reports. This set of audit tools was presented to the monitoring team and the PCMs described the development and implementation of these tools during a group meeting at the facility during the on-site tour. The tools appeared to be tied somewhat to the Settlement Agreement (e.g., the titles of some of the forms also had letters and numerals from the Settlement Agreement) or to a response to an investigation or survey conducted by DADS regulatory surveyors. Examples of tools presented to the monitoring team are listed below. It was unclear as to whether every one of these tools was being implemented by the PCMs: o acute care plans o health management plans o quarterly and annual nursing assessments o medication administration and medication administration records o pre-treatment sedation o injury prevention and review of DCP daily observation note entries o restraints o psychological care o behavior plans o psychiatric care o habilitative environment o physical and nutritional management o physical and nutritional management plans o communication of individuals o most integrated setting practices o integrated PSPs • State standardized required reporting: LSSLC collected and reported data on a number of areas as were required by DADS central office. Again, these data were	

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		not incorporated in any useful manner or into any type of overall facility QE plan or report. These measures are listed below. o employee injury data from July 2009 through January 2010 o client injury data from June 2009 through December 2009. Hundreds of pages of data were provided to the monitoring team. The pages presented the total number of injuries per resident, the types of injuries and the frequency per staff work shift, however, the information was not summarized or analyzed in any manner that provided any useful information to the facility and its management and administration. o quarterly trend analysis (1st quarter FY10, September through December 2009 for (a) unusual incidents, (b) abuse and neglect allegations, (c) injuries, and (d) restraints. These reports included some brief description of the data, but the report was not an analysis of trends. Instead, it reported data for the quarter in bar or pie charts. The data were not very useful alone, but could be incorporated into a facility QE plan while still meeting the reporting requirement to the state. • Incident Management Meeting: this was a daily meeting during which senior management reviewed the previous day's incidents, emergency restrictions, restraints, injuries, and aggression between individuals. In addition, once each week, the Director of Admissions and Placement attended to give an update on referrals for placement, placements, and admissions referrals. Although this meeting was not a QE meeting, it might be used by facility administration (in addition to the PIC described in section E2 below) as a way to incorporate QE activities into the daily operation of the facility. <u>Other Comments</u> As LSSLC develops tools and processes for the QE department, it should consider having the contents of the facility's tools line up with the monitoring team's checklist tools. This would ensure that the activities engaged in by facility managers and staff, and the actions that are monitored by QE staff, are in line with the actions of the monitoring team. The Monitors have discussed this with DADS central office staff. Of note, however, is that the monitoring team checklist tools are likely to be revised somewhat following the completion of the set of baseline reviews. The DADS policy called for "an integrated, reliable and valid data information system that compiles relevant individual and organizational data…" (page 2); the facility to "review and monitor the integrity and validity of the data…" (page 6); and that "data must be tracked 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." (page 7). The QE system at LSSLC	

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		was not meeting this requirement. These clear directives from the policy require that the QE department: • Ensure validity of the items in each tool (i.e., whether the tools actual measure what it is they are purporting to measure). This requires an examination of the definitions the PCM used to determine if the item was present or not. o Experts in each discipline area should be involved in this process, both at the facility level, and at the state level (i.e., central office discipline heads). o Detailed definitions are needed for PCMs to determine the presence or absence of the indicator. • Ensure the tools are reliable; that is, that there is agreement across auditors, that unintentional bias by PCMs is reduced, and that observer drift does not occur (a change, over time, in what is accepted to indicate presence of the indicator). The policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. Most of these were in operation (or were soon to be in operation) at LSSLC. The policy required a program improvement committee; this was in place at LSSLC and is described in section E2 below. The policy also required performance improvement reports. These were to be self-assessments completed on a monthly basis, but there was no evidence of any type of performance improvement report. The documents described in this section of the report (e.g., notes from PIC meetings, information collected by PCMs, and submission of some data to central office) did not meet this requirement of a regular performance improvement report. The Settlement Agreement, in addition to requiring quality assurance activities for the overall compliance with the agreement, specifically required quality assurance and quality review activities in a number of provisions, including F2g, L3, T1f, and V3. The Director of Quality Enhancement was not aware of the Settlement Agreement detail or of these specific requirements. A typical outcome measure usually assessed and tracked at facilities, such as LSSLC (and most agencies and companies) is the satisfaction of individuals, their families and LARs, staff, and affiliated providers (e.g., local hospital, community physicians, community employers). These groups are surveyed to assess their satisfaction across a range of areas, some broad, some very specific. The LSSLC QE program should include a regularly	

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		occurring measurement of these types of satisfaction. Moreover, this was indicated in the policy on page 3, that is, to "...assess individuals satisfaction with services and supports." The self-advocacy activities of the individuals at LSSLC can be one way (but should not be the sole way) to gauge individual satisfaction and can be part of the QE plan at LSSLC. The monitoring team had the opportunity to attend one of the facility's self-advocacy meetings. It was for individuals who lived in the Oak Hill and Castle Pine units. It was held in the chapel and approximately 30 individuals attended. Self-advocacy meetings were coordinated by social workers at LSSLC. The agenda for this meeting included a number of brief presentations by LSSLC administrative staff and covered topics such as recreation activities, religious activities, voting, guardianship, advocacy, and staffing. A number of individuals stood up and made comments about things going on in their lives, such as moving to a group home, going to the rodeo, and getting a new job. Overall, it was a pleasant session, but was more of an information sharing meeting than a self-advocacy meeting. Future activities might include instruction and practice in group problem solving (e.g., identifying problems, generating possible solutions, considering the advantages and disadvantages of each possible solution, and choosing a solution by a vote), and more involvement and leadership by individuals rather than staff.	
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.	This provision item required the facility to analyze the data collected by the QE processes that are implemented at the facility. As indicated above, little analysis of data occurred at LSSLC and should be one of the facility's priorities as it moves forward in developing an active and functional QE system. During the time of the on-site monitoring tour, the facility was not doing anything meaningful with the data collected by PCMs. If anything of importance was noted or found, PCMs and QE staff apparently inform relevant administrators and managers via a process called "immediate request for action." It was unclear to the monitoring team as to whether this was a formal process with forms, or if it was informal and done via email. <u>Performance Improvement Council</u> The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Enhancement. Part of the PIC's role is to look at data collected by the QE department. Members of the PIC should review, discuss, and respond to the data via corrective action plans and via other mechanisms that the facility might develop. PIC meeting notes and minutes were presented to the monitoring team for the period of July 2009 through February 2010. The minutes from July 2009 through October 2009 included some detail of the topics and discussion at the meeting, however, beginning	

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		with November 2009, the notes were nothing more than an agenda. Further, based on these notes/agenda, the PIC appeared to function more as a vehicle for sharing of information with administrative staff rather than a meeting to review and thoroughly discuss data and responses to data. This was not in line with LSSLC's own policy, "LSSLC Performance Improvement Council, Facility Operational Procedures Manual, Committee and Councils-16," dated 11/1/08. This document described a requirement for the PIC in developing and approving the facility's annual plan, including "performance indicators for consumer services," the appointment of Performance Evaluation Teams (PET) and Performance Improvement Teams (PIT), and the types of data to be presented at each PIC meeting. <u>Performance Evaluation Team</u> Performance Evaluation Teams (PET) were not in place at LSSLC even though these were required by their own policy noted above and in the DADS policy on Quality Enhancement. <u>Corrective Action Plans</u> There was no organized process for developing, implementing, disseminating, monitoring, documenting, or modifying corrective action plans at LSSLC. There was some discussion during monitoring team's group meeting with the PCMs and individual meeting with the Director of Quality the Enhancement regarding recently developed plans of correction for issues that were identified by DADS regulatory surveyors. Two examples were regarding discovered injuries and hypothermia.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	See comments above in section E2.	
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.	See comments above in section E2.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	See comments above in section E2.	

Recommendations:

1. Provide the Director of Quality Enhancement, her PCM staff, and the Settlement Agreement Coordinator with training opportunities and with

opportunities to coordinate with QE departments at other facilities and with central office.

2. Assess whether the Director of Quality Enhancement has a reasonable set of job responsibilities in addition to her QE responsibilities.

3. Update facility policies to be in line with newer state policies. If the facility policy is no longer needed, it should be removed from the facility's policy manual. If facility policies are to differ from state policies, provide documentation of approval from the state central office discipline head.

4. Create a facility QE plan that is functional, meaningful, and useful to LSSLC managers, administrators, and clinicians. The plan also needs to include:
    - all requirements of the DADS policy on Quality Enhancement,
    - a narrative,
    - all of the areas listed on page 4 of the policy, and
    - the Health Care Guidelines

5. Modify and create quality enhancement PCM review tools that are in line with the monitoring team's checklist tools. Note, however, that the monitoring team's review tools are likely to be revised following the completion of the baseline reviews at all of the facilities.

6. Ensure reliability of data collected by PCMs.

7. Subject the QE department to quality assurance/enhancement review, feedback, and assessment.

8. Incorporate non-Settlement Agreement quality enhancement activities into all of the processes and programs of the QE department.

9. Develop a satisfaction measure for individuals, staff, family members and LARs, and affiliated agencies and providers.

10. Ensure self-advocacy groups learn skills of self-advocacy. For example, add a structured problem-solving decision-making component to the self-advocacy group meetings. Utilize these self-advocacy groups as one way of gauging individual satisfaction with services and supports at the facility.

11. Provide program improvement reports as per the policy.

12. Graph quality enhancement data using line graphs.

13. Implement CAPs when needed, following all requirements of E2, E3, E4, and E5 above.

14. Develop a QE report that includes a summary of all activities, data, trends, and narrative that describes important points about the data.

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 Personal Support Teams PDP Process Training Curriculum 9/22/09 o DADS 2009 Your Rights in a State Supported Living Center Booklet o DADS Positive Assessment of Living Skills (PALS) o Training transcripts for four direct support professionals o Admission and Referral Meeting Agenda 4/20/10 o Admission Rights Assessment for Individual #147 o Skill Acquisition Plans for Individual #147 o Progress Notes for Individual #147 o Sample of PSPs and corresponding PALS assessments for: • Individual #136 2/16/2010 • Individual #554 2/17/10 • Individual #552 4/8/09 • Individual #57 11/18/09 • Individual #526 3/3/10 • Individual #426 10/20/09 • Individual #180 11/4/09 • Individual #437 6/9/09 • Individual #587 2/17/10 • Individual #354 9/17/09 • Individual #418 3/3/10 • Individual #169 3/3/10 <u>Interviews and Meetings Held</u>: o Interview with Stacie Cearley, Program Compliance Monitor o Interview with Kathy Thompson, Quality Enhancement Director o Informal interviews with various care staff, QMRPs, nursing staff, and psychology support staff in homes and day programs throughout campus <u>Observations Conducted</u>: o Hidden Forest Morning Unit Meeting 4/20/10 o Oak Hill Morning Unit Meeting 4/22/10 o Daily Incident Management Meeting 4/20/10 and 4/22/10 o Human Right Committee Meeting 3/23/10 o Annual PST meeting for Individual #332 o Annual PST meeting for Individual #524

	o Annual PST meeting for Individual #99 o Residences 520, 523, 529 524, 542, 549, 550, 557, 559, 561, 563, and 643 o Large Workshop o Small Workshop
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items in this provision were either not developed or not yet implemented thoroughly enough to allow for monitoring. The state policy #004 Protections, Services, Treatments, and Supports dated 2/15/10 was still in draft format. Further, the facility had not yet developed a policy to address this section of the Settlement Agreement. The development of person directed plans was a clear focus of the facility PSTs and the quality assurance team; they were aware of areas that needed to be addressed to improve the person centered planning process. A sample of 12 PSPs was reviewed and two annual PST meetings were observed during the onsite monitoring visit. As evidenced by PSPs reviewed, the facility had made some progress towards developing person centered plans for individuals served at the facility in the past year. The implementation dates on the 12 PSPs reviewed ranged from 6/09 to 3/10. Individual #552 did not have a current plan developed within the past 365 days. Plans developed in 2010 used the new DADS format dated December 2009. The plans clearly showed an effort to gather information on the individual's needed supports, interests, preferences, and long-term goals. Although much of this information was included in the plan and discussed by the team at PSP meetings, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision. The cover page of each PSP reviewed using the new format included a list of "what's most important to the person?" and "how is this supported?" These lists tended to be individualized and comprehensive. This information would be a great starting point for the development of individualized outcomes, however, it was observed at annual PST meetings and in observation of day programs that this information was not used to prioritize outcomes for the person. For example, at the annual PSP meeting for Individual #332, the team began the meeting with a discussion of what was important to her, as well as her preferences, likes, and dislikes. The team identified activities that they knew she enjoyed, but stopped short of brainstorming around new activities in which she might have liked to participate, given what they knew about her. The team recognized that socialization was a priority for her and communication was a barrier to this, yet the team did not develop any outcomes that addressed exploring alternate forms of communication. Instead, the team continued most of her outcomes from the previous year, even though the outcomes did not address priorities that the team discussed during the meeting. For instance, she had outcomes for money management and self administration of medication. Neither of these was identified as a priority, nor were they areas that appeared to be very

	important to her given other challenges that contributed to her lack of independence and control over her day (although the monitoring team understands that the facility's interpretation of the ICFMR regulations required all individuals to have training outcomes for these two areas). The next logical step in this discussion, in line with person directed planning, would have been to gather input from the team, particularly the direct care professionals, on what activities staff could introduce to explore new activities and acquire new skills. The team discussed community placement for Individual #332 at the PST meeting, but did not integrate this discussion into developing outcomes or a plan of action. During the discussion around community placement, the individual's guardian/parent stated that she wanted her daughter to remain at the facility. The team acknowledged her opinion and offered to provide additional information on community placement if the family was interested at a later date. A similar discussion occurred during the PST meeting for Individual #524. His mother attended the meeting by phone. She was adamant that she did not want her son moved from the facility. The team had a brief discussion around community placement and what supports he would need in the community. The facility was doing a good job of pulling together information into a written plan that offered a complete picture of the individual's preferences, vision, and summary of supports that the person was receiving. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision The plan should describe who will provide and monitor each support, how the support will be provided, and a schedule of when each support will be needed. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the plan.

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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:	The DADS policy for this provision had not been developed at the time of this on-site review. LSSLC did not have facility policies in place addressing the role of Personal Support Teams (PSTs) or the development of Personal Support Plans (PSPs). Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in	PST meetings were facilitated by the QMRP whose responsibilities included keeping the group focused on an agenda and making sure all sections of the PSP were addressed. QMRPs were also responsible for obtaining assessments, coordinating, and monitoring services for the individual. Informal interviews with QMRPs during the review process	

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	developing, monitoring, and revising treatments, services, and supports.	revealed that they were generally aware of the range of supports and services being offered to the individuals whom they supported. The monitoring team's understanding was that DADS was in the process of revising the state policy regarding Person Directed Planning. As noted, LSSLC staff involved with the coordination of PSPs were preparing for these changes and revisions to the PSP process. For example, QMRPs were preparing for additional training and for a re-organization of the components of the PSP meeting (e.g., placement of the living options discussion at the beginning of the meeting). The monitoring team will review the implementation of these new policies and procedures during the next onsite monitoring visit.	
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.	The two PST meetings observed during the monitoring visit confirmed that PSTs were comprised of an interdisciplinary team based on the individual's strengths, preference, and needs. Staff who provided direct support to the individual were present at both meetings and given the opportunity to contribute to discussion. Both individuals and their LARs were present at the meetings. PSP signature sheets for Individual #57, Individual #180, and Individual #587 indicated that all relevant team members attended annual team meetings. Direct care professionals interviewed confirmed that they attended team meetings and were given the opportunity for input into the plan both at the meeting and outside of the meeting by ongoing discussion with the QMRP regarding supports and services. All of the direct care professionals interviewed reported that if a service or support was not adequately addressing an individual's need, they could discuss it with the QMRP or other team members, and that those team members would address the issue and call the team together if needed. It was evident from a review of PSPs that documentation from a variety of relevant disciplines was reviewed in preparation of the annual PSP meeting. Additional review of this item will occur during future monitoring visits.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	A wide range of assessments were performed prior to PSP development. It was not, however, evident that these assessments were used to address barriers to each person achieving his or her individualized vision. PALS was the functional skills assessment tool used by the facility and specifically named in the state policy. While this assessment offered a basic checklist of functional skills, it did not include a means of prioritizing skills based on each person's individual preferences. This resulted in generic outcome development rather than individualized outcomes for each person. Additional assessments were completed for each person by specialist and clinicians.	

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		Recommendations from these assessments were included in isolated plans rather than being integrated into a comprehensive plan for providing support to each person throughout his or her day. In both PST meetings observed during the monitoring visit, communication needs were a priority for each individual. There was no evidence that the individual's communication needs had been assessed and addressed adequately for planning by the team. Further, while the PSP may have been present in the individual's record, it was not up to date in many areas. Some examples are listed below: • The psychiatric diagnosis in the quarterly review was different than that recorded in the PSP for Individual #344 and Individual #54. • The PSP did not include a plan for pica, even though it was listed as an active problem for Individual #423. • The PSP for Individual #203 did not include an action plan for aggressive behaviors, which was noted as worsening in the most recent psychiatric review. As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs. This provision of the Settlement Agreement will continue to be reviewed during upcoming monitoring visits.	
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 noted in section F1c, it was not evident that assessment results were used to develop, implement, or revise PSP supports. According to direct support professionals interviewed throughout the monitoring visit, treatment was provided independently, for the most part, by each separate discipline. According to interviews with direct support professionals, therapists, nursing staff, and psychologists did not work with direct support staff to ensure integration of plans into supports provided throughout each individual's day. The PSP included information from specific disciplines in isolated sections of the PSP, rather than integrating assessment information into one plan that staff could use to support the individual. A narrative section in the PSP describing the individual, his or her preferences, how he or she spends the day, and what supports are needed throughout the day may help the team see how services should be integrated into a lifestyle rather than looking at supports from each discipline as isolated interventions.	

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		A majority of the PSPs reviewed did not include a summary of services and supports that the individual was receiving. PSPs should clearly address all of the supports that an individual will receive, including a description of the residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided, and what types of supports the individual will need throughout the day. Some of the most recent plans developed by the facility were moving towards this type of discussion in the PSP. For instance, the PSP developed on 3/5/10 for Individual #169 included recommendations from the SLP on how staff should support the individual in making choices and expressing herself. This was evident in the following strategies: 1. Staff should reinforce Individual #169 when she verbalizes by acknowledging her attempt to communicate and by making eye contact with her. Staff should also respond to her other modes of communication in a similar fashion. 2. When communication breakdown occurs, Individual #169 should be encouraged to use a community poster on the home. Staff should provide hand over hand assistance for pointing to pictures on the communication poster in order to allow her to comment, make a request, and interact with staff. 3. Staff can also help Individual #169 anticipate daily events by pointing to pictures of activities before they occur (i.e. pointing to lunch picture prior to going to lunch). Overall, however, it was unclear to the monitoring team as to how the facility determined what types of protections, supports, and services to provide for the individual. Most alarming was the apparent absence of a way to determine what to teach an individual. This was particularly evident in the PSP for Individual #99. He was an adolescent, was nonverbal, needed one to one supervision, and could do little for himself. His PSP had only five goals, listed below. 1. grasp the button to button his pants, to be worked on from 6:00-6:30 a.m., 2. greet others with a handshake, to be worked on between 9:00-10:30 a.m., 3. participate in a leisure activity for 1 minute, 4. hold money until he reaches his destination, and 5. to point to his mouth when asked “where put oral medication.” At a minimum, this individual should have had goals and objectives related to language and communication (e.g., making requests), basic learning skills (e.g., motor imitation), prevocational training (he was an adolescent and transitional planning should have begun), independent personal hygiene, more involved social interactions, and more	

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		detailed independent leisure skills. Surprisingly, one team member stated that Individual #99 should be pretty busy with all of these goals. The monitoring team does not agree. When comprehensive policies are in place to address PSP development, the facility needs to be sure that QMRPs receive updated training on developing plans. QE staff should continue to monitor plan development and provide assistance and training as needed.	
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).	Community placement was discussed at both of the PST meetings observed, although the discussion was limited, and both teams agreed that placement at the facility should continue for the individual. PSPs reviewed included a discussion of community placement and supports that would be needed if services were provided in the community. Individuals and their LARs were provided with information regarding community placement. The facility had a weekly Admission and Referrals Administrative Meeting to review the status of referrals to the facility and request for community placement from individuals residing at the facility. There were 17 individuals on the community placement list. Request dates for placement ranged from 5/9/09 to 3/11/10. Two of the 17 had dates set to move into the community. The committee also reviewed requests to transfer homes within the facility. There were 23 requests for transfers within the facility dating from 12/08 through 4/10. None of these individuals were scheduled to move. Thirty individuals were on the list for a community tour. None of these had been scheduled, although 14 of the individuals had been on the list for more than six months. One individual had been referred for a community tour over a year ago. The facility needs to ensure that requests for moves are followed up on in a timely manner and community tours are scheduled when recommended by PSTs. Very few PSPs included a description of the individual's current day program. There was generally not consideration of community-based day programs or supported employment by the team. Although, trips were planned in the community each week, active treatment did not focus on functional learning in the community and outcomes in individual PSPs did not focus on training in the community. Observation at the two sheltered workshops on campus indicated that there were many individuals who had valuable job skills that would transfer well into a more integrated setting. The facility had a limited vocational program that offered individuals a chance to work on contract work in a segregated setting. Employment was not discussed at either of the PST meetings observed the week of the monitoring visit. The facility had a Human Rights Committee (HRC) in place to review any restriction of	

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		rights for the individual. Observation of an HRC meeting during the monitoring visit revealed that the committee generally looked at alternatives to interventions to reduce restrictions of rights. Informal interviews with staff in various homes throughout the facility showed that staff were aware of the rights of individuals whom they supported and there was an understanding that they were responsible for safeguarding each individual's rights. There were clear, easy to understand posters placed in all buildings observed throughout the campus regarding individual's rights.	
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:	This provision will be reviewed in greater detail by the monitoring team following the implementation of newly developed facility policies to address PSP development and implementation.	
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;	PSPs included a table with a list of what was most important to the person. This list, however, was not consistently used to develop outcomes based on the individual's preferences. Teams should use this area of the PSP to list specific things that are important for the individual and then include supports that the individual needs to maintain or increase the occurrence of those things in his or her life and address any barriers to occurrence. The PSPs that were reviewed typically had an outcome to participate in some community activity, but plans did not state functional learning that would take place while the individual was in the community. The focus appeared to be on community participation in specific events rather than integration into the community. Opportunities for community integration should be addressed at the facility and will be reviewed further during future monitoring visits.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies	As discussed in the summary above, outcomes were not always related to the individual's preferences and vision. Most outcomes did not contain enough information to be observable and measurable, and plans were not consistent in addressing supports needed to achieve outcomes.	

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	to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step. For example, the PSP for Individual #135 had several action steps that were not clear in stating what level of participation was needed by the individual to complete the outcome and what supports would be needed for successful completion. The following action steps were included in her PSP: 1. Will attend to being read an article of interest 3 of 5 trials. 2. Will respond positively to soothing sounds provided by the instructor 1 of 5 trials 3. Will tolerate her coin purse on her lap There was no clear direction on how staff could determine if she was "attending," "responding positively," or "tolerating." Staff implementing these action steps did note that "progress was shown." This offered the team no information on how the action step was implemented or what the individual's response was to implementation. Most of these action steps were continued from the previous PSP. The team should discuss what barriers were present if the action steps were not completed and develop new strategies for implementation. Goals and objectives often seemed to be templated rather than individualized. Most of the sample included learning to manage money as a goal. For example, Individual #90 and #367 both had money handling goals with little individualization and there was no mention of the need to monitor Individual #90's money management during manic episodes. On a positive note, there were some PSPs in place with measurable outcomes that related to the individual's vision. In one example, the PSP for Individual #426 included the following action steps: 1. Will remove all objects from pockets of clothing with no assistance 8 days in a one month reporting period. 2. Will write a list of items he would like to purchase from sale paper with no assistance 4 days in a one month reporting period for 2 consecutive months.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Achievement of this provision item varied widely across the PSPs reviewed. The facility needs to put into place specific procedures for developing PSPs that integrate all protections, services, and supports that the individual needs. PSPs were developed with an apparent goal to capture each individual's needs, goals, preferences, and abilities in one document as described by each treating discipline, but there was little evidence of true integration of all services into one comprehensive plan. Plans need to include not only a list of services and supports that the person is receiving, but also a description of	

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		how and when those supports will be implemented and monitored. Further, there was very little evidence that interventions, treatment plans, or clinical care plans were integrated. Psychiatry was not mentioned in the PSP even for the individuals who were actively taking psychotropic medications. There was no evidence that psychiatry and psychology worked together on the behavioral aspects of the PSP in an integrated fashion.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Plans designated staff responsible for implementation of the objectives by discipline, but lacked specific methods for implementing outcomes or, in most cases, target dates for completion of outcomes.	
	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	Outcomes did not include specific interventions, strategies, and supports individuals might have needed to achieve outcomes. See comments at #F2a2 above.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Most plans reviewed specified a method for data collection and the frequency of data collection, but did not guide staff as to what type of information should be collected. Some, but not all, action plans designated who would review and monitor implementation and progress towards outcomes. Plans should specify the data that staff will record for each action step. Data collection should indicate the individual's level of participation, supports needed, and response to the activity.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The facility did not have a process to ensure coordination of all components of the PSP. See comments throughout this report regarding the lack of integration of services for individuals.	

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F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The PSPs did not provide comprehensible information that would guide direct care staff in providing necessary supports. See specific details and examples in F2a above.	
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.	The facility will need to develop a policy that requires monitoring of PSP implementation and criteria for reviewing data and modifying plans as needed. Efficacy of all support plans should be evaluated by team members with a system that includes input from direct care professionals responsible for implementation, oversight, and monitoring by plan developers. A larger sample of implementation data will be reviewed during upcoming monitoring visits and additional comments will be made regarding the monitoring and updating of PSPs.	
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	As noted above, staff responsible for developing plans will need to be trained on new policies relating to PSP development. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. There was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual plans initially or when they were updated or modified. This provision of the Settlement Agreement will continue to be reviewed in upcoming monitoring visits to determine the adequacy of training in providing team members with the skills to develop and implement comprehensive, effective plans for individuals.	

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	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.		
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.	A sample of new admissions was not reviewed during this onsite baseline visit. All but one of the PSPs in the sample was revised annually. The PSP for Individual #552 was developed on 4/8/09. There was no evidence that the team had met to review the plan at the time of the monitoring visit. A sample will again be reviewed for compliance with this provision during future monitoring visits.	
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.	As noted above, quality enhancement activities with regards to PSPs were in the initial stages of development and implementation. According to the Program Compliance Monitor, a review of PST meetings and PSPs had recently been implemented. Many of the concerns mentioned in this section of the report were areas identified in the monitoring process. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	

Recommendations:

1. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, psychiatry, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation. The PSP should be a genuine team effort with vigorous discussion amongst the members, not simply a report of a templated plan. In this way, the each individual can benefit from an approach to treatment that

is fully integrated, not simply a paper exercise.

2. PSP should specify the data that staff will record for each action step. Data collection should indicate the individual's level of participation, and supports needed, and describe the individual's response to the activity. Further, individualize treatment plans and specifically behavioral plans and integrate this with psychiatry.

3. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed. Update the diagnoses as the treatment plan changes them.

4. Continue team building efforts at the facility to foster an attitude that encourages and supports integrated services. Some specific recommendations are:
    a. Direct support professionals should accompany the individual to medical appointments or sick call to provide the best possible history to the provider of care. If the direct care professional cannot be present, some sort of report should be passed along in a format that is useable to the medical provider.
    b. At least one of the psychiatric providers is interested in attending the PSP meetings. If the psychiatrist cannot attend in person, then the PSP team should consider allowing psychiatry to join via teleconference so that the team can integrate the psychiatric treatment into the plan.
    c. When possible, direct care staff should attend team meetings of psychiatry to provide more immediate input to the team.

5. Develop a system to monitor the PSP, the implementation of services and supports, and the timely modification of plans when services and supports are not effective.

6. Provide training to QMRPs on how to address concerns and issues that guardians/parents/LARs might express in regards to community placement.

7. Ensure that requests for moves are followed up on in a timely manner and community tours are scheduled when recommended by the PST.

8. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.

9. Implement a quality assurance process for assessing whether PSPs are developed consistent with this provision.

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:** • Meeting with Gale Wasson, facility director • Meeting and discussion with Dr. B Carlin, medical director • Meeting with Dr. B. Carlin, medical director; Mary Bowers, Chief Nurse Executive; Luz Carver, QMRP Director; and Nellie Matthews, HST coordinator • General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the on-site tour. • Attendance at psychiatry clinics • Various meetings attended by monitoring team members as indicated throughout this report. • Review of LSSLC Plan of Improvement, August 2009, January 2010.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement. As noted elsewhere in this report, meaningful integration of clinical services was not evident in most areas at the facility. Some detail is provided below in section G1.

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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.	A plan was not in place to address this item. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. A number of discussions with the facility director, medical director, chief nurse executive, and QMRP director as well as with staff at various levels of management, within clinical services, and at the direct care level indicated that meaningful integration of clinical services was not evident. On the other hand, there was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians. Achieving integration will be a facility-wide process, that is, will require that all	

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		departments and all levels of staff participate. The facility director acknowledged that facility senior management was well aware of the need to put integrated processes into place. She was pleased with the legislative actions that had led to more support and resources for the facility. Her goal was to pull medical, psychiatry, and psychology closer together. She also felt that pharmacy would be part of this as well. The senior clinical staff referred to the integrated progress notes (IPN) as one way they had worked towards integrated clinical services. This system began about a year ago on 4/1/09. The previous system had separate sections in the record for physicians, nurses, psychologists, psychiatrists, and so on. The new IPN was a running clinical note into which each clinical professional added updates and observations. The medical director liked having all of the information "right there in one place for each individual." He also described the record as containing consultation notes, and an active/inactive list of medical concerns. Nurses followed up on orders from consultation and also made entries in the IPN. Nurse managers and the QE nurse were also responsible for reviewing all IPNs. A separate set of notes was kept by the direct care professionals and was called "observation notes." These were running comments describing general and specific information about the individual's day. These were not part of the integrated progress note system. There was also a home shift log, and a nurses' 24 hour shift report. A lot of responsibility for coordination and communication fell to the QMRPs. The QMRPs needed to read all of the IPNs and associated consultations. They did not make entries into the IPN, but needed to follow-up on items that required actions (e.g., medical appointments, calling a PST meeting). Facility management should assess the QMRPs' workload to ensure that they are able to attend to IPNs in a sufficient manner. Any medical or clinical related concerns of direct care professionals were to be brought to the attention of the nurse and the nurse was then responsible for taking that information forward (e.g., injury, medication). The medical director described having a lot of cooperation from other disciplines and from his medical staff. He noted that three physicians were available and onsite every weekend. A morning meeting was held at each unit and recent incidents and changes in medical and healthcare status were discussed. The combination of all of these notes, recording systems, and meetings can contribute to an integrated system of clinical supports. A goal for the facility was to ensure that all	

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		disciplines could attend and participate in the annual PSP meeting. Clearly more work needed to be done and, to add to this need, the facility was going to be going through further changes over the next few months. For example, a nurse practitioner had been added to the medical staff in order to relieve the medical director's routine caseload duties to provide for more administrative and oversight. In addition, the clinical staff were anticipating the start of a new full-time facility psychiatrist. Even so, additional full-time psychiatry hours may be needed in order to provide continuity of care for the every individual. A new focus on integrated clinical practice and communication will lead to improved provision of service to the individual. For example, there was a bit of friction between the physicians and the remainder of the PST at the time of this onsite tour because the physicians felt that their input was not often incorporated into planning, for instance, when to consider a procedure a medical safety precaution versus a restraint. Similarly, psychiatry felt constrained in prescribing PRN (i.e., as needed) medications for particularly difficult individuals or in times of crises. A weekly meeting between the facility director and the medical staff was initiated during the week of the onsite tour. It is hoped that these types of opportunities for communication and sharing of concerns will occur frequently at LSSLC.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	A plan was not in place to address this item. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. At LSSLC, the method of approval of outside consultations was to go through the attending primary care physician who then wrote the orders.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and

outcomes.

3. Continue to conduct the newly initiated weekly meetings with the physicians, psychiatric providers, and the facility director.

4. Conduct more integrated assessments, particularly in the area of risk assessment (see section I).

5. Address confusion regarding (a) what constitutes a restraint versus a medical intervention to safeguard the individual and (b) what is appropriate treatment of psychiatric symptoms versus use of an agent to "control behavior." This requires that leadership set an in-house standard with the staff members so that in times of crisis, confusion on the part of staff members is reduced.

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:** • Meeting with Gale Wasson, facility director • Meeting and discussion with the LSSLC medical director, Dr. B Carlin. • Meeting with Dr. B. Carlin, medical director; Mary Bowers, Chief Nurse Executive; Luz Carver, QMRP Director; and Nellie Matthews, HST coordinator • General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the on-site tour. • Attendance at psychiatry clinics • Various meetings attended by monitoring team members as indicated throughout this report. • Review of LSSLC Plan of Improvement, August 2009, January 2010.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement Nevertheless, across the facility, there was great desire for there to be coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision. The facility, however, lacked direction in how to obtain this outcome. This was due in part to (a) the recency of attention to this provision, (b) some confusion as to who was responsible for each component and the monitoring of each component, and (c) a plan of improvement that did not provide guidance or direction regarding specific actions to be taken.

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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	A plan was not in place to address this item. Further, there were problems throughout the facility regarding the completion of assessments as indicated and detailed throughout this report. Facility senior medical administrators noted that assessments were addressed via a	

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	developments or changes in an individual's status to ensure the timely detection of individuals' needs.	nursing policy for assessments, Health Status team, PSP meetings, and PSPA meetings. Although these forums and processes may set the occasion for assessments to occur and be reviewed, an overall system of managing assessments at LSSLC was still in need of development. The chief nurse executive described an upcoming initiation of tracking system of routine assessments.	
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 medical director noted that ICD-9 diagnoses were used by physicians and psychiatrists, and that DSM diagnoses were used by psychologists. As noted by the monitoring team, however, many diagnoses remained in place from diagnoses assigned years and years ago. This was very prevalent in psychiatric and psychological assessments. More work will need to be done to bring these diagnoses up to date.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The ongoing development of acute care plans, health management plans, and medical care plans for those individuals who were most medically fragile may be a way for the facility to monitor progress on this provision item. In psychology, clinical interventions were not consistently appropriate nor were they based on assessment results (see sections K5 and K9 below), or modified in response to clinical indicators (see section S3 below). At the time of the baseline visit, the records of individuals reviewed that are listed in the "Documents Reviewed" section of this report under sections J and L indicated that more work needed to be done to meet this provision item. Problems in treatment, monitoring those treatments, and timeliness of interventions were evident and discussed in sections J, L, and M, as well as the health care guidelines of this report.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	A plan was not in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used across all disciplines. An evaluation of the outcome of health care plans for acute illness was one way proposed by the facility. This may be one component of an overall system to look at clinical indicators. Psychiatry was looking at changes in behavior to track efficacy of treatment, but no other indicators were evident	

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		in medicine or psychiatry.	
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.	A plan was not in place to address this item. The Health Status Team was operating and reviewing each individual every six months, but, as noted elsewhere in this report, the HST did not look at all aspects of health (it looked primarily at risk) and there were major problems with the implementation and interpretation of facility and state policy.	
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.	A plan was not in place to address this item and without clinical indicators identified (see H5 above), treatments and interventions cannot be modified in response to clinical indicators. The facility referred to the HST as the way health status was monitored at LSSLC. Again, see comments above in section H5.	
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.	Policies, procedures, and guidelines were not in place regarding Section H. Facility management also acknowledged that this provision item was not yet being addressed. Even so, the HST coordinator tracked due dates for review, sent out reminders, and oversaw the high-risk individuals to ensure that meetings occurred. She reported this information to the DADS central office.	

Recommendations:

1. Develop and implement policy.
2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.
3. Consider an electronic medical record; this may be an effective way to implement clinical indicators and provide for accurate tracking.
4. Consideration should be given to using lab matrix as clinical indicators for tracking psychotropics.
5. The physicians and psychiatrist should be given input into development of appropriate indicators for each discipline.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #006: At Risk Individuals o LSSLC Policy: Health Status Team 10/16/09 o DADS Health Status Team Training Curriculum March 2010 o DADS Risk Assessment Tools, dated 8/31/09 o LSSLC Log of individuals diagnosed with pneumonia since 7/09 o LSSLC Log of ER visits since 7/09 o LSSLC Log of Hospitalizations since 7/09 o List of all injuries by individual since 7/09 o List of 10 individuals with the most injuries 7/1/09-2/4/10 o List of 10 individuals causing the most injuries to peers 7/1/09–2/4/10 o Review of HST documents, restraint documentation, and injury reports for individuals listed in the below in section J of this report. o List of individuals and their risk level in the following areas: • Seizures • Challenging Behaviors • Dehydration • Osteoporosis • Skin Integrity • Weight • Hypothermia • Respiratory • Medical Concerns • GI Concerns • Constipation • Cardiac • Urinary Tract Infection • Polypharmacy • Injury • Diabetes • Choking • Aspiration o Sample of PSPs including: • Individual #136 2/16/2010 • Individual #554 2/17/10 • Individual #552 4/8/09 • Individual #57 11/18/09

	• Individual #526 3/3/10 • Individual #426 10/20/09 • Individual #180 11/4/09 • Individual #437 6/9/09 • Individual #587 2/17/10 • Individual #354 9/17/09 • Individual #418 3/3/10 • Individual #169 3/3/10 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct care professionals, QMRPs, nursing staff, and psychology support staff in homes and day programs throughout campus <u>Observations Conducted</u>: o Hidden Forest Morning Unit Meeting 4/20/10 o Oak Hill Morning Unit Meeting 4/22/10 o Daily Incident Management Meeting 4/20/10 and 4/22/10 o Annual PST meetings for Individual #332 and Individual #524 o Residences 520, 523, 529 524, 542, 549, 550, 557, 559, 561, 563, and 643
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. LSSLC had a policy in place titled "Health Status Team" dated 10/16/09. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. A Health Status Team (HST) was in place that included the Primary Care Provider, Psychologist, Residential Services Representative, Risk Manager, Health Status Coordinator, Nurse, Psychiatrist, Dentist, Habilitation Therapist, Dietician, QMRP, and Pharmacist. The team was chaired by the Primary Care Provider. Risk statements in PSPs were general and often conflicted with information included in the PSP by specific disciplines. Comprehensive risk reviews that consider and address factors that contribute to each risk area need to be completed and all staff need to be aware and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose of the identification of at-risk individuals.

	There was consensus among staff at the facility that contributing factors to challenging behaviors at the facility were staffing ratios, overcrowded homes, and grouping of individuals with challenging behaviors. The facility did not have a plan in place to address any of these factors. Facility management teams need to look at trends around challenging behaviors and address known contributing factors in a plan of correction.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The facility policy mandated a risk review at least every six months for each individual by a Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. The HST had developed a list of individuals at high risk in each of the following categories: aspiration, choking, weight, cardiac, constipation, dehydration, diabetes, hypothermia, GI concerns, medical concerns, injury, osteoporosis, seizures, skin integrity, urinary tract infections, challenging behaviors, polypharmacy and respiratory. Determining risk levels was done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed. HST notes were a part of every record that was reviewed with the exception of Individual #9. Most were unsigned by the physicians and some had no signature from any discipline (e.g., Individual #203, Individual #367). Further, there were no sign–in sheets on many of the HST documents leading the monitoring team to wonder whether or not there was a meeting to discuss the risk of the individual (e.g., Individual #203, Individual #367). The medical director could not elucidate the HST risk measurement process during his interview other than to say each discipline rated the risk as they saw it. Below are examples of risk assignments and risk incidents. • Individual #203 had escalating aggressive behaviors and wore a helmet because of persistent head banging. Risk from behaviors was rated as "moderate" according to the HST, but the PBSP from 1/31/10 stated, "head banging and keeping him safe is the most critical need." Additionally, he had several self-injurious behavior injuries each month from 11/09-4/10. • Individual #321 had a one-year history of declining weight and intractable vomiting requiring fundiplication, but was rated low risk in nutritional area of the HST.	

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		• In the case of Individual #90, psychiatry listed "manic spree over months in the notes, but behavior was listed as moderate risk, even despite persistent behavioral problems including insomnia for days on end. • Also see the information presented in sections M3 and M5 of this report under nursing care. • Also see the information presented in section O2 of this report under Minimum Common Elements of Physical and Nutritional Management.	
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 policy stated that the Health Status Team (HST), chaired by the Primary Care Provider, would ensure a preventative approach to the health and safety of persons served by assigning each individual a risk level/rating. High Risk (level 1) would apply to an acute or unstable condition that would require increased intensity of intervention to achieve an optimal health outcome. Furthermore, it stated that individuals discharged from the hospital should have their risk level reviewed by the physician. The policy mandated that once a high risk condition was identified, the PST would meet within five working days to formulate a plan. The plan must be implemented within 14 days and incorporated into the individual's PSP. The PST was required to meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition was stabilized and the risk level was reduced. The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. Review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels are assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. Some examples of inconsistencies in risk scores and actual risk factors for individuals are provided below. • The PSP for Individual #169 stated that she was at low risk. The HST risk level list indicated that she was low risk in all areas except medical concerns and weight; she was rated as moderate risk in these two areas. A review of information included in her PSP revealed that her dining plan included information indicating that she was at risk for dehydration. Her medical history	

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		information included seven seizures in the past year and one incident of pneumonia since December 2009. • The HST risk level list for Individual #354 indicated that he was at low risk in all areas other than choking. He was rated at moderate risk for choking. His PSP noted that he had pica and was on a ground diet which would indicate that he was at high risk for choking. Additionally, he had a PT plan in place addressing his risk for falls. He used a gait belt and contact guard for ambulation. His nutritional assessment indicated that he was at risk for dehydration, weight loss, and constipation. His behavioral assessment listed several challenging behaviors including hurtful to self, hurtful to others, destructive to property, and disruptive behaviors. • The HST risk level and PSP for Individual #426 indicated that he was low risk in all areas, yet he had a plan in place to monitor for choking following a choking incident in the past year resulting from overstuffing his mouth. He also displayed a risk for challenging behaviors according to behavioral data summarized in his PSP, including 11 to 12 incidents of property destruction per month, and 23 to 24 episodes of physical aggression per month. He had a plan in place for the use of restraints due to aggression. His nutritional assessment noted that he was at risk for unintended weight loss, constipation and dehydration.	
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 PST. The PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Direct care professionals reported that they were notified of changes in plans by the therapist or their supervisor and implementation of changes began immediately. Throughout the monitoring visit, direct support professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff were not always able to accurately identify risks or identify supports needed to monitor those risks. Direct support staff seemed to think that specific disciplines, such as nursing or therapy would monitor any risk for individuals, so they did not need to know information regarding risk. Direct support staff need to be able to identify risk factors for each individual whom they support and know signs of crisis so that they can seek help when necessary. They need to be able to provide support in a manner that will minimize risk to individuals. Further, the PSPs often did not include the risks that were articulated in the current progress notes. An example was noted for Individual #423 who had active pica, but it was not noted in the PSP. Individual #106 was noted to be a pedophile in the psychiatric	

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		notes, however, there was nothing in the PSP to indicate that he was not allowed to be within arm's reach of children or at events with children who live at the facility.	

Recommendations:

1. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

2. HST should be more than a "cut and paste exercise." Rather, the risks associated with current problems and the depth of those current problems should be discussed in a PST format. The current system leaves the monitoring team wondering whether this was done in a meeting format that had meaningful discussion about the risks and proposed solutions for each individual.

3. Establish written policies regarding the types of incidents that would require immediate review of the individual's risk assessment including unusual incidents, hospitalizations, and ER visits.

4. All staff should receive individual specific training on each safety and health care risk identified for the individual(s) they are assigned to support.

5. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support.

6. Facility management teams need to look at trends around challenging behaviors and address known contributing factors in a plan of correction.

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:** <u>Documents Reviewed</u>: o Curriculum vitae of Dr. Jane, Dr. Buckingham, and Dr. Orocofsky (the psychiatrist scheduled to join the facility staff in May 2010) and the Texas Medical Board Profile for each psychiatrist o Texas medical board profile and resume for Doug Douglas, PA o The following documents from the records of the individuals listed below: • Inactive/Active Problem list/Face sheet • Initial Psychiatric Evaluation and all follow-up notes from 9/09 to present • MD orders since 9/09 • Interdisciplinary progress notes for the past three months • Polypharmacy review • Seizure records from 12/09 to present • Lab and radiology reports from 4/09 to present • Most recent EEG report • Adult prevention care flow sheet • DISCUS and MOSES assessments from 9/09 to present • Medication administration records from 12/09 to present • Most recent social work update • Restraint reports from 11/09 to present • Most recent EKG • Most recent PBSP and PSP • Injury reports from 11/09 to present • Consent for treatment/psychotropic medications from 4/09 to present • For these individuals: ▪ Individual #113, Individual #306, Individual #119, Individual #532, Individual #147, Individual #321, Individual #106, Individual #31, Individual #344,Individual #423, Individual #488, Individual #180, Individual #203,Individual #367, Individual #9, Individual #569, Individual #480, Individual #116, Individual #169, Individual #90, Individual #54 <u>Interviews and Meetings Held</u>: o Dr. Janes, psychiatrist o Dr. Buckingham, psychiatrist, and Doug Douglas, PA o Gale Wasson, Facility Director <u>Observations Conducted</u>: o Psychiatric clinics with Dr. Janes

	o Psychiatry rounds and psychiatry clinics with Dr. Buckingham and Doug Douglas o Walking rounds with psychiatry in Hidden Forest units o The following individuals were reviewed in psychiatric clinics in addition to the record reviews noted above: • Individual #417, Individual #213, Individual #407, Individual #490, individual #552, Individual #68, individual #466, Individual #217, Individual #424, Individual #587, Individual #253, Individual #477, Individual #226, Individual #116, Individual #169.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State and facility policies in psychiatry to address this provision of the settlement agreement were in development. It is expected that the new policies in psychiatry, plus additional direction from the state, will assist LSSLC in working towards meeting this provision of the Settlement Agreement. Overall, there was fragmentation of psychiatric services because there were part-time psychiatric providers (two psychiatrists and one PA). One of the psychiatrists was present one day per month, and the other two providers were on site together one day per week for a total of only seven hours in duration. During the time period of July 2009 through April 2010, there were two other psychiatrists who left their positions at the facility. One of the psychiatrists had difficulty with the facility's policy and procedures regarding consent for treatment with psychotropic medications. Although the issue was resolved by the time of the on-site tour, the psychiatrist was no longer present at the facility. Records indicated that the psychiatrists had difficulty with the timely transcription of notes. For example, in three cases, (Individual #119, Individual #31, and Individual #9), the notes from a 9/29/09 appointment were not available until 12/17/09 for review and signature. In a fourth example, (Individual #106), the quarterly review was dictated on 1/7/10, but not transcribed until 3/25/10. Senior administration support will be needed for psychiatrists to obtain the support they need to be a more integral part of the overall functioning and service provision at LSSLC. In the interview with psychiatric providers, great concern was expressed over the issue of treating psychiatric symptoms versus the prohibition of chemical restraints. They were concerned that individuals who required stat medications for control of acute symptoms were not always able to receive the medication because of the appearance of it being a chemical restraint. There had been push back by nursing staff over dosages of medications ordered for particularly difficult individuals and, at times, this had hindered their ability to provide for optimal psychiatric care of individuals (the case of Individual #147 was one example). This had also occurred for physical restraints where helmets or gloves were required for self-injurious behaviors. For example, one of the psychiatrists noted, while discussing the difficulties in trying to obtain hospitalization for individuals experiencing acute psychiatric needs, that LSSLC would be

	in a better position than were hospitals to provide the care and treatment of these individuals if the psychiatrists had the ability to freely utilize all the tools that psychiatry would use in an inpatient unit, such as approved medical restraints and stat IM medications. The cascade of events that occurred subsequent to the decompensation of Individual #147 provided an excellent illustration of the results of such problems. Psychiatry made rounds prior to reviewing the individuals in a treatment-team-like setting, that is, although a group of professionals were meeting in a manner that looked like a treatment team, it did not, in the opinion of the monitoring team, operate like a treatment team. The treatment teams did not include direct care professionals and this was a frustration for the psychiatric providers. Further, the nurse case manager in attendance might or might not have known the individual being discussed. The psychology department had a shortage of one psychologist and the one present at the team in the clinics observed by the monitoring team was clearly was not familiar with the individuals who were being discussed. Psychiatry admitted to difficulty with coordinating medications that may overlap with neurology. An example was Individual #569 where Clonazepam was in use in a high dose. Psychiatry wanted to decrease the dose, however, neurology may have been the original prescriber of the medication and it was unclear from the record for what the medication was originally prescribed. The process for coordination was for psychiatry to write an order to request input from neurology. Neurology clinics occurred monthly and most individuals were sent out to the neurologist's office, off-campus. Lab values were dictated into the quarterly psychiatry reviews, however, there were some reviews that did not contain the pertinent monitors and, in some cases, the abnormal lab was noted, but there was no attempt to explain the abnormal number. Some examples were: • Individual #367: the neutrophil count was noted as low, but there was no attempt to correlate it clinically. • Individual #488 had no lipid levels in the record despite being on quetiapine. • Individual #344 had persistently elevated prolactin levels and subsequent amenorrhea without an attempt to change the probable offending psychotropic medication or work-up the problem further over the past year. The individual was presented at psychiatry clinic and further reduction in the medication was ordered as well as repetition of the prolactin level. Psychiatry did not appreciate the problem of amenorrhea, elevated prolactin, and its effect on future bone loss and risk of endometrial cancer. The psychiatry providers were in agreement that the DISCUS and MOSES were not useful instruments in tracking symptoms of tardive dyskinesia or side effects from medication. The psychiatrists signed the documents, but rarely made comments regarding the incidence of side effects. A psychiatrist, who was no longer at the facility, made notes stating that the positive elements scored were a result of underlying problems, not as a side effect of the medication. Many of the DISCUS or MOSES instruments in the records had no signature by psychiatry, but were signed by the primary care provider. One of the current psychiatrists remarked that the DISCUS had little validity because the raters had different levels of expertise and the rater may change each time. All psychiatry providers were more familiar with the AIMS scales and would prefer to use those scales to monitor for tardive dyskinesia.

	The MOSES is difficult to use with a nonverbal population because of the need for the rater to interpret the nonverbal cues in order to answer the questions on the instrument. As a result of the use of a side effect monitor (MOSES) that is considered useless by the psychiatric providers, it is possible that side effects were not thoroughly monitored or understood. Experience differed among the nursing staff regarding psychotropic medications. It was possible that akathesia as a side effect was labeled as aggression or agitation. In a lengthy discussion with one of the psychiatrists, the issue of many of the individuals being nonverbal complicated the accurate reporting of psychotropic medication side effects was raised. There needed to be some integration of learning to monitor psychotropic side effects with the use of the rating tool and this is best studied by a team effort with the psychiatrist as the leader in educating and facilitating this effort.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	There were, at the time of the on-site tour, three providers of psychiatric services at LSSLC: Dr. Janes, Dr. Buckingham, and Doug Douglas, PA. Mr. Douglas was supervised by Dr. Buckingham. Both psychiatrists were board certified in general psychiatry, and Dr. Janes was also board certified in child and adolescent psychiatry. A full-time psychiatrist, Dr. Orocofsky, was scheduled to join the staff on 5/1/10. She was also board certified in general psychiatry. They all appeared to be qualified to provide psychiatric services. There is no specific "extra training" in the field of psychiatry for working with individuals with developmental disabilities. Dr. Janes recently rejoined the staff, offering four to six hours per month. Dr. Buckingham and Doug Douglas were at the facility on Thursday of each week for approximately six hours. All three of the providers had previous work experience in working with individuals with developmental disabilities. Dr. Orocofsky will be full-time beginning and appeared to have previous work experience in the fields of mental and mental retardation, per her CV. In discussions with the current psychiatric providers, they were eager to learn additional clinical information about this group of individuals, but found it difficult to discover relevant formal CME activities in the field. The facility director indicated in a separate interview that there were two additional full-time slots that were vacant for psychiatry.	
J2	Commencing within six months of the Effective Date hereof and with	Individuals at LSSLC who received psychotropic medication had not been evaluated and diagnosed in a clinically justifiable manner. Of the sample of records reviewed, only	

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	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.	individual #569 had a fully detailed psychiatric evaluation conducted by a qualified psychiatrist as outlined in Appendix B. The remainder of the sample had reviews completed, however, many lacked any psychiatric diagnosis of Axis I-V. These appeared to be nothing more than a quarterly review that was labeled as an "Initial Evaluation." Psychotropic medication was under the supervision of a board certified psychiatrist in all records that were reviewed in the sample. There was a PA who regularly wrote for psychotropic medication and was under what could be called "loose supervision" by psychiatry. Quarterly reviews for the residents being seen by the PA occurred simultaneously with reviews being conducted by the psychiatrist within the same room. Per the PA's self-report, if he had a question regarding one of the individuals that he was reviewing, he can interrupt the psychiatrist who was reviewing a different individual and ask him the question. This did not appear to be the best way to review the individuals because it was somewhat confusing and distracting to have two separate teams going on simultaneously.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Psychotropic medications did not appear to be used explicitly in the manner prohibited by the detail in this Settlement Agreement item, however, the lack of integration of psychiatry with other aspects of programming at the facility, combined with the need for behavioral and educational treatment improvements, made it possible that psychotropic medications were prescribed in the absence of a comprehensive treatment program. The psychiatric providers were clear in their interviews that they never felt pressured by staff to medicate individuals in order to control behaviors. On the contrary, the providers felt "overly constrained" to not use psychotropic medications to medicate behaviors and all were in agreement that the prohibitions against chemical restraints, as well as the confusion over restraint versus medication for symptoms, was a big problem at LSSLC and may interfere with best practice treatments for individuals.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment 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	At the time of this baseline on-site tour, psychiatry was not involved with monitoring or assessing pre-treatment sedation strategies for routine medical care. The current procedure was for the attending medical provider to order the sedation and then the individual was returned to the infirmary for post-sedation monitoring. The monitoring in the infirmary appeared to be adequate. There was no evidence from the records reviewed that psychiatry had any input into the appropriateness of sedation for provision of medical care. The medical section of the PSP	

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	minimize or eliminate the need for pre-treatment sedation. The pre-treatment 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.	frequently commented on "no contraindication for sedation for medical care." This section of the PSP was under the purview of primary care at LSSLC.	
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.	At this baseline on-site tour, the psychiatry hours were four to six hours per month for the child psychiatrist, and six to eight hours weekly each for the PA and psychiatrist. As of 5/1/10, it was expected that there would be a full-time psychiatrist in addition to the hours noted. The facility director stated in the interview that there are two additional full-time openings available in the budget for psychiatry. It is impossible to meet all elements of the settlement agreement with the number of psychiatry hours provided at LSSLC. If the psychiatry staff can be increased to at least 2.5 FTEs of psychiatry, then there is a more realistic probability of meeting this goal. This may be possible with increased recruitment of a qualified psychiatrist. LSSLC had increased the number of children and adolescents in its population. Retaining the child and adolescent psychiatrist should be an important consideration for this facility.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	As indicated in section J2 of this report, there did not appear to be but one individual (#569) with an initial evaluation that met this provision item. The quarterly reviews completed by the current psychiatrists appeared to contain Axis I-V diagnoses in the records reviewed after January 2010.	
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	The Reiss screen was not in use at LSSLC. Since July 2009, there had been 11 new admissions to the facility and none included a Reiss Behavioral Screen. There was no current "screening process" for psychiatric issues in place for new admissions. The psychiatry providers were unfamiliar with the Reiss screen. The medical director	

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	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.	planned to consult psychiatry "as needed" for new admissions. Of concern was that there were a number of individuals who had one or more psychiatric diagnoses and were not receiving psychotropic medication despite having diagnoses that usually required such medication. A list of 12 individuals to whom this applied was produced by the facility during the on-site tour. For example, Individual #250 had a schizoaffective disorder. As indicated above in section J2, there was only one record of those reviewed with a comprehensive psychiatric assessment as outlined in Appendix B.	
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.	None of the records reviewed had any evidence of integration of behavioral interventions with pharmacological treatments. Each quarterly review contained a summary of behavioral targets with numbers, such as self-injurious behaviors, aggression, or other behaviors for reporting at the quarterly review, however, there was no evidence from the record or at the psychiatric clinics of discussion between the psychiatrist and other members of the team regarding utilizing any collaboration or integration of interventions to address the behavior problems. The PBSP and PSP documents reviewed appeared to have templated language regarding medication usage under the psychiatry or psychology section. The psychology section discussed the interventions used, however, there was no real integration of these sections. This represented missed opportunities for treatment to be as effective as possible. For example, Individual #203 has an elegantly stated functional behavioral assessment that the psychiatrist should have incorporated into the treatment plan. The 4/15/10 quarterly psychiatric review noted that aggressive behaviors were worsening since the individual was taken off one to one supervision by staff. Ativan was then increased from 5.0 mg/day to 6.5 mg/day in order to "decrease bothering by his surroundings." There did not appear to be an attempt to design a behavioral strategy, instead medication was used. The medical director attempted to attend psychiatry clinics and was present during some	

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		of the clinics at the onsite review, however, psychiatry rounds conflicted with medicine rounds in the infirmary, that is, they occurred at the same time. There did appear to be an attempt for medicine and psychiatry to integrate. The medical director also confirmed that he was able to contact the psychiatrists when they were not in clinic to consult with them regarding individuals who were difficult to manage. Once LSSLC has full-time psychiatrists on staff, this provision of the Settlement Agreement should be easier to meet. To determine whether an integration of pharmacological treatments at the facility was occurring, the monitoring team will look for the following: • Facility description of the system to integrate the pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, • Medical records for evidence of collaboration across disciplines, • Evidence that behavioral data are considered in decisions regarding pharmacological treatments, • Interviews with psychologists and nurses to ascertain process of collaboration, • Evidence of coordinated care when psychiatric illness occurs, • Existence of a PBSP, and • Participation and discussion during meetings regarding individuals.	
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-	At the time of this baseline review at the facility, the psychiatrists did not participate in formulation or updates of a PBSP. There did not appear to be any evidence from review of the sample records that this occurred. The PBSP and PSP discussed psychotropic medication and behavioral intervention separately, that is, in a non-integrated manner. Discussion during the quarterly review meetings that were observed by the monitoring team appeared to address the idea of reducing medication to the minimum required for each individual. There was, however, some reluctance to reduce the medications of individuals who were stable on the current regimens due to previous experience by the psychiatrists in destabilizing individuals who then require hospitalization. Psychiatric hospitalization was very difficult to obtain for the individuals residing in LSSLC. This was corroborated by the medical director who reviewed the progressive difficulty with obtaining psychiatric beds for individuals at the facility. It was good to see that the psychiatrists were being thoughtful when considering all possible consequences of medication reductions. Better access to psychiatric beds, and/or better ability of LSSLC to deal with psychiatric crises, may provide a more safe context in which medication reductions can occur.	

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	pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.		
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.	There was no evidence of the facility meeting the requirements of this provision of the Settlement Agreement. The psychiatrists reported this process for consent and approval was lengthy and frustrating, especially when an individual's symptoms were worsening. The providers shared that this process influenced their consideration to change an individual's regimen to a new medication. All three providers acknowledged the due diligence of needing appropriate consent for psychotropic medication, but felt the process needed streamlining (see section J14 below).	
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.	Beginning with the January 2010 quarterly reviews done by each psychiatric provider, a section that required comments regarding polypharmacy was included within the notes. There appeared to be a genuine concern by each psychiatric provider to reduce polypharmacy as much as possible for each individual without jeopardizing his or her stability or progress. The pharmacy was in charge of quarterly polypharmacy reviews. A Pharm.D. had recently joined the LSSLC staff (within the month prior to the on-site baseline review), but had not attended any of the psychiatric clinics until the week of the on-site baseline review and was in attendance for only part of one clinic. Only two of the records in the sample reviewed had polypharmacy reviews done on a quarterly basis. The reviews did not appear to be up to date with regard to monitoring labs. • For Individual #180, the provider requested, more than once, for a lipid profile to be ordered. When it was finally ordered in 1/10, it was not recognized and a request was again generated during the next polypharmacy review on 3/2/10.	

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		• Individual #203's review from 3/4/10 appeared to be an exact copy of the 11/30/09 polypharmacy review, including a comment that there had been no DISCUS done since 11/08. The record contained a DISCUS for 11/7/09 and 2/10/10. The director of the pharmacy was also a new employee and was trying to get up to speed on everything. The monitoring team expects improvement in this area and, in particular, expects that the hiring of a Pharm.D. and the integration of the Pharm.D. into the facility's operations, to be a facilitator in helping LSSLC to meet the requirements of this provision of the Settlement Agreement.	
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.	MOSES and DISCUS were used at the facility, but were not part of an organized system to monitor side effects of medications. DISCUS was a tool used by the facility for assessing tardive dyskinesia. It was implemented on a two to six month basis per the record review. It was unclear as to why some individuals were monitored more frequently than others. Moreover, as noted below, little follow-up was conducted based upon the results of these assessments. • Individual #180 had only one DISCUS in the record. • Individual #569 had three DISCUS in the record between 9/09 and 4/10. • Individual #119 had two DISCUS recorded, but neither were signed by a psychiatry provider. • Individual #106 had one DISCUS recorded between 9/09-4/10. • Individual #344 has a positive AIMS (9/7/09) recorded by the psychiatrist for abnormal movements, but subsequent to that, three DISCUS measurements (1/25/10, 3/18/10, and 4/20/10) that were each recorded as 0. • The DISCUS on Individual #480 was 2 on 11/7/09 and 0 on 4/13/10 without any explanation in the notes or on the instrument as to why there was a change. • Individual #480 had a 2003 initial note in the record that remarks on whether he may have TD or a tic disorder. MOSES was implemented on a three to four month basis, per the record review. There were MOSES that were completed, but did not reflect the medication that the individual was actually taking (e.g., Individual #423), thereby making the monitoring team wonder about the accuracy of the reporting of the side effects. Individual #106 had one MOSES for the time between 9/09-4/10. There was a question as to how the instrument is utilized by the psychiatric providers. Individual #480 had only one MOSES in the record between 9/09 and 4/10 that recorded a score of 9 with restlessness and contortions noted, but no comment from the provider, only a signature.	

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		At LSSLC, both the DISCUS and MOSES appeared to be a paper exercise that was largely ignored by psychiatry. Psychiatry was much more familiar with the AIMS and willing to implement that as the monitor for tardive dyskinesia. The MOSES was seen by psychiatry as useless and, therefore, was unlikely to be a meaningful process for monitoring side effects at LSSLC.	
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.	There were no psychiatric treatment plans in place (other than a listing of medications the individual was receiving and any relevant target behaviors) at the time of the on-site baseline review of LSSLC. There were no quarterly reviews of the records reviewed that specified timelines for the expected therapeutic effects to occur. Target behaviors were monitored and described in the first half of the note by psychology, which may or may not have correlated to specific psychotropic medication interventions. At the time of the quarterly reviews, the psychology part of the reviews was handed to the psychiatrist who then dictated his part of the review at the time of the quarterly review. It was unclear from the record as to who was monitoring for the effects of the medication. There was a lack of comprehensive of psychiatric services. Two examples are presented below. • In the case of Individual #480 who had a provisional diagnosis of Tourette's disorder and was taking Risperidone for treatment. There was, however, no mention of tics and no list of target behaviors associated with this disorder. • Individual #9 was noted to pace and sleep poorly per the quarterly review by psychiatry, was taking two separate medications, both of which are known causes of akathesia, yet there was no mention in the quarterly review as to what the etiology of this symptom might be. The psychiatrist seemed to rely upon the numbers generated by psychology regarding the target behaviors in order to determine efficacy of treatment, rather than to wonder if this is related to side effect or perhaps even a missed diagnosis of PTSD.	
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	There was no uniform consent process in use at LSSLC. Different psychologists handled consent for new psychotropic medications in different manners. Social work made the initial contact to the legal guardian after an order was written during the psychiatric review appointment. From that point, individual psychologists may take it upon themselves to walk it through the entire process in order to have it expedited through the HRC. Depending upon the provider queried, the average time from written order of a medication to implementation, was anywhere from one to three weeks in order for the individual to receive the medication.	

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	procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	There was confusion at the facility regarding how often the HRC meets- some providers saying weekly and some saying monthly. There was a process for emergency approval, however, this required the provider to deem the medication an emergency and the providers were reluctant to classify starting, for example, an antidepressant, as an "emergency." The full effect of this process was to frustrate the providers of psychiatric care as well as delay treatment of psychiatric illness and this resulted in protracted continuation of symptoms. It was unanimous among all three psychiatric providers that this was the most frustrating part of their jobs at the facility. One of the providers felt as if there was reluctance on the part of facility administration to approve psychotropic medication. Examples of delay of treatment include the following examples below. • Individual #424 was placed on suicide watch after it was noted she was depressed and hearing voices telling her she was no good. She was prescribed both an antipsychotic and antidepressant on 2/11/10, but the medication was not started until 3/3/10, after consent was obtained on 2/27/10. In addition to the complex consenting process, the individual was off campus on 2/27/10 and this led to additional delays in the start of medication. • Individual #68 was noted to have problems with insomnia and medication was prescribed on 3/11/10. On 4/22/10, the individual had not yet received the medication and nursing requested another order be written during the psychiatric clinic because consent had finally been obtained. The individual with unresolved insomnia went untreated for a period of six weeks. None of the records contain consents for all psychotropic medications. The consents that were present were not particularly meaningful in that they did not explain, in lay terms, the most likely side effects of the medications. It was a recitation of side effects from the PDR or some similar type reference. This was difficult for family members to understand. The social worker was charged with presenting this consent to the family and it would seem that perhaps the nurse should be responsible because nursing was more involved with the monitoring of side effects at LSSLC. This would also remove one person from the chain of people handling the current consent process.	
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,	This process was not in effect at LSSLC. The psychiatric providers noted in their clinics that this was a problem and that they had to be cautious about implementing a decrease in any of the anti-seizure medications, attempting to assure that it was psychiatry's medication and was not being prescribed exclusively for seizure treatment. There was no formal coordination process at the time	

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	through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	of this on-site baseline review. Neither psychiatry nor neurology was present in PST meetings. The burden of this coordination had fallen upon the primary care providers who also were attempting to keep up with monitoring of the levels of the medications as well as the appropriate lab tests. The fact that many of the individuals went offsite to the neurologist also led the monitoring team to wonder about effective communication, both in monitoring of levels and reporting them to neurology, as well as neurology sending EEG reports and consults back to the facility in a timely manner.	

Recommendations:

1. Develop and implement a written policy regarding psychiatric services, including a description of evidence based treatments of psychiatric disorders and the typical dosages and courses of treatment for individuals with psychiatric illness.

2. Increase the number of psychiatry hours to at least 2.5 FTEs. This is reasonable given the current population of 227 individuals who were requiring psychotropic medication. It would be ideal to retain a child/adolescent psychiatrist on staff because LSSLC was accepting children and adolescents into the milieu.

3. Restructure the pay scale for full-time psychiatry positions to better reflect the shortage of physicians in this specialty. Rural locations often pay higher salaries in order to attract quality applicants. At the time of the baseline review, the psychiatry openings at LSSLC had been posted for at least one year.

4. Streamline the flow of the psychotropic consent process to lessen the time from order writing to the individual receiving medication so that no individual waits more than 48 hours for medication.

5. Schedule ongoing weekly meetings between the facility director and the primary care and psychiatric providers so that all stakeholders in the process of direct care provision at the highest level can discuss concerns about potential obstructions to the provision of care and implementation of the Settlement Agreement. Misunderstandings between the providers and the administration about what constitutes restraints, both physical and chemical, need resolution to avoid individuals not receiving appropriate medical and psychiatric care.

6. Integrate psychiatry and psychology in a meaningful way so that psychology provides psychiatry with data that is helpful in directing not only medication treatment, but suggesting behavioral interventions that might pre-empt further needs for medication and allow psychiatry to use the lowest effective dose of medication for that particular individual. Psychiatric providers feel that up to date weekly data on behaviors would provide more meaningful and useful behavioral data.

7. PBSP and PCP meetings should include direct psychiatry input. Multi-disciplinary treatment team meetings should allow for open discussion with psychiatry about medication and behaviors as well as revision of diagnosis. This would allow for psychiatry to teach team members the recognition of side effects, such as akathesia. The monitoring team acknowledges the logistical difficulties in psychiatry attendance at the many

meetings that occur at LSSLC.

8. Involve psychiatry in the planning and implementation of pre-treatment sedation, such as participation in discussion with the PST regarding possible alternatives (e.g., behavioral treatments). This is an example of one area where further integration and inclusion of psychiatry is likely to result in more comprehensive treatment for the individual.

9. Consideration should be given to use the AIMS with administration the responsibility of psychiatry. All psychiatric providers at the facility are more familiar with the use of this instrument and would prefer using it to the DISCUS.

10. Psychiatry needs to be responsible for monitoring for their medication side effects. A specific lab matrix needs to be designed for psychotropic medications, including, for example, second-generation antipsychotics, and antidepressants that have a potential for elevating prolactin such as Paroxetine. A lab matrix is a set of appropriate monitors (e.g., lab test results) for medications that is used by psychiatry and neurology. For example, it was in use at El Paso SSLC at the time of the on-site baseline tour. The process could also highlight lab result abnormalities that might be suggestive of neuroleptic malignant syndrome. This might be very useful for clinicians and staff.

11. Address the need for available hospitalization for psychiatric crises, either with local hospitals or on-campus at the facility.

12. Individual records should have better organization, with elements pertinent to treatment retained, but others thinned from the records. Records were frequently not organized in similar fashion, making record review for the psychiatrists difficult as well as risking oversight of important lab or notes.

13. Conduct psychiatric assessments as per Appendix B of the Settlement Agreement. Further, because of the lack of initial evaluations containing important history to document the psychiatric diagnosis in the record, there were questions as to where the diagnosis originated. Frequently there were no symptoms recorded in the progress notes to justify the diagnosis of record. Consideration should be given to each individual as the psychiatry staff increases in size to look back at the history and attempt to create a comprehensive summary for each individual.

14. Implement the Reiss Scale as required by the Settlement Agreement.

15. The new Pharm.D. should be utilized by psychiatry to attend clinics and help them to stay up to date with lab monitors, polypharmacy reviews, and drug-drug interactions.

16. Conduct polypharmacy reviews.

17. Psychiatry needs to be involved with ongoing peer review from outside. Perhaps a teleconference with psychiatrists from academic institutions nearby or from another state facility could be employed to provide such services.

18. The psychiatric providers were interested in continuing education in the field of developmental disabilities, so whatever the state can do to offer education in this area would be helpful.

19. The list of individuals produced that have a psychiatric diagnosis but are not on psychotropic medications needs to be reviewed for referral to psychiatry for evaluation since there has been a great deal of turnover in this department over the past year, it is unlikely that these individuals

have had a thorough evaluation.

20. A system to coordinate neurology and psychiatry needs to be put into place.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed:</u> o QMRP/Social Worker/Psychologist Roster, 3/25/10 o LSSLC Staff Ratio Data, undated o Data Cards, revised 3/9/10 o Questions About Behavioral Function (QABF) o Functional Behavior Assessment, undated o Momentary Time-Sampling Data Sheet, revised 3/9/10 o Psychology Department list of IQ and SQ dates, undated o Psychological Evaluation Format, 6/06 o Behavior Intervention/Human Rights Committee meeting minutes, 08/18/09, 09/21/09, 10/20/09, 11/24/09, 12/17/09, 01/26/10 o Functional Assessments for: • Individual#369, Individual #41, Individual #426, Individual #556, Individual #31, Individual #516, Individual #255, Individual #444, Individual #99, Individual #517, Individual #593, Individual #333, Individual #480, Individual #245, Individual #57, Individual #192, Individual #460, Individual #134, Individual #131, Individual #166, Individual #39, Individual #305, Individual #285, Individual #565, Individual #504 o Positive Behavior Support Plans (PBSPs) for: • Individual #369, Individual #41, Individual #426, Individual #556, Individual #31, Individual #516, Individual #255, Individual #444, Individual #99, Individual #517, Individual #593, Individual #333, Individual #480, Individual #245, Individual #57, Individual #192, Individual #460, Individual #134, Individual #131, Individual #166, Individual #39, Individual #305, Individual #285, Individual #565, Individual #504 o Psychology Evaluations for: • Individual #516, Individual #444, Individual #54, Individual #484, Individual #10, Individual #487, Individual #552, Individual #482, Individual #96, Individual #260, Individual #211, Individual #84, Individual #503, Individual #301, Individual #244, Individual #369, Individual #41, Individual #556, Individual #517, Individual #593, Individual #99 o Psychological Summary for: • Individual #46 <u>Interviews and Meetings Held</u>: o Gail Husband, Assistant Director of Programs o Meeting with the Psychology Department o Marvin Stewart, M.A, Program Compliance Monitor

	o Jay Bamburg, Ph.D., Consultant to the Psychology Department o Vernon Wiggins, M.A., Associate Psychologist III o Richard Mendola, M.A., Associate Psychologist III o Mike Fowler, LPA, Associate Psychologist V o Troy Finch, Psych Assistant o Ranleigh McAdams, M.A., Associate Psychologist III o Robin McKnight, M.A., Associate Psychologist V o Psychiatric Clinic • Staff Attending: Dr. Mark Janes, Psychiatrist; Ranleigh McAdams, Psychologist; Janet Bunton, RN; Marvin Stewart, M.A. • Individuals Presented: Individual #116, Individual #344, Individual #169 o Psychiatric Clinic • Staff Attending: Doug Douglas, PA; Kari Staley, Associate Psychologist III; Marvin Stewart, M.A. • Individual Presented: Individual #119 o Meeting with the QMRPs <u>Observations Conducted</u>: o Observations occurred in various day programs and residences at LSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training, etc.), and • Implementation of behavior support plans
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: It was obvious to the monitoring team that LSSLC had begun to address many of the items in this provision of the Settlement Agreement. Nevertheless, there were several areas that required additional attention and improvement. These included improvements in data collection and presentation, functional assessments, and Positive Behavior Support Plans (PBSPs). Additionally the program was without several critical behavioral systems, such as inter-rater agreement of data, measures that monitored and ensured that PBSPs were implemented with integrity, and a peer review system. The effective and efficient use of these components of applied behavior analysis (ABA) has been demonstrated to be critical to achieving meaningful behavior change. In order to achieve this level of

	competence in ABA, the monitoring team believes that those writing and monitoring PBSPs need to receive the training, supervision, and experience associated with board certification as a behavior analyst (BCBA). Finally many individuals at LSSLC did not have psychological assessments, and many more had assessments that were more than 20 years old. The facility needs to develop a plan to ensure that all individuals have a current, accurate, and complete psychological assessment.

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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.	All of the psychologists at LSSLC had a masters degree, however, none were board certified behavior analysts (BCBAs) at the time of the on-site tour. Two psychologists were enrolled in the five course sequence that leads to the BCBA, and one psychologist was waiting to hear if she possessed the coursework and supervision necessary to sit for the BCBA national exam. The attainment of BCBA certification is important because it represents an objective measure of competence in applied behavior analysis. Additionally, the course sequence necessary to sit for the national exam presents practical and important information on topics, such as data collection, graphic presentation and interpretation of data, functional assessment, and behavioral interventions that the monitoring team believes would be critical in enhancing the behavioral skills of the Settlement Agreement. Additionally, the facility hired two behavioral consultants. Jay Bamburg, Ph.D., was hired to consult on behavioral systems issues and data collection, and Edward Hutchison, BCBA, was hired to provide supervision for psychologists enrolled in the BCBA program. At the time of the on-site tour, no plan or policy for obtaining BCBAs for all psychologists who wrote Positive Behavior Support Plans (PBSPs) was in place.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The director of Psychology position at LSSLC was vacant at the time of the on-site tour. A new director was hired and was scheduled to begin working in May 2010, shortly after the on-site tour.	
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	Peer review meetings were not occurring at LSSLC. An active peer review system would allow the psychology staff to share their strengths and insights with each other and would result in improved overall quality of PBSPs. Peer review at the facility should occur weekly and, at minimum, consist of PBSP authors,	

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	of PBSPs.	direct care professionals (DCPs) who implement the plans, and those who supervise the implementation of behavior plans. The psychology department conducted monthly Behavior Intervention/Human Rights Committee meetings that were designed to review and approve new and annual PBSPs and human rights issues. It is possible that the Behavior Interventions/Human Rights meetings could be expanded to include the opportunity to present challenging cases for peer discussion and feedback, beyond those that come up for scheduled initial approval or annual review. Additionally, the monitoring team recommends that peer review be extended by adding monthly external peer review meetings consisting of, at minimum, other Texas DADS BCBAs/supervisors (perhaps by teleconference). External peer review committees play an important role in the development of the skills of applied behavior analysts and the facility's ability to provide ABA services that meet the generally accepted professional standard of care as defined by the Settlement Agreement. External peer review can provide constructive and useful feedback to behavior analysts at the facility. This type of peer review was recently highlighted in an article of the Association of Professional Behavior Analysts (www.apbahome.net, Peer Review for Behavior Analysts, by Jim Johnston, Ph.D., BCBA-D). Operating procedures for these peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and	At the time of the on-site tour, the facility was in the process of experimenting with new data systems. Most of the homes and vocational/day programs toured were utilizing a data system which consisted of DCPs recording target behaviors and their times of occurrence. In these sites, DCPs also recorded written summaries of each individual's behavior during that shift. Another system, observed in homes 559A and 523 with a limited number of individuals, utilized a data system where antecedents, the target behavior, and consequences (also known as an ABC data system) for each target behavior were recorded. Additionally, a momentary time sample data system was observed with some individuals in home 523 whereby times were predetermined and DCPs recorded whether the target behavior occurred or not at those specific times. The facility was also experimenting with how best to record data. The data in the majority of homes were recorded on separate sheets kept in the vicinity of each individual. The data for the ABC system was recorded on cards kept in each staff's pocket. The written summaries were generally written at the end of the DCP's shift and were kept in each individual's record.	

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	interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	Each of these data systems had merits. Whatever system, or combination of systems, the facility adopts, it is important that it is flexible enough to be sensitive to individual needs. That is, it must be able to accurately capture both high frequency behaviors, as well as low frequency high intensity behaviors (e.g., elopement, infrequent but intense property destruction, or physical aggression). Equally important is that the data collection system needs to be able to be collected by DCPs with integrity. Many of the psychologists interviewed indicated that they were not confident that the data collected were reliable. The most direct method for assessing and improving the integrity with which data are collected is to regularly measure inter-observer agreement (IOA). It may be that some data systems are too complex (e.g., ABC systems that require the collection of multiple antecedents and consequences for each target behavior) for some DCPs to collect reliably. Under those conditions, the data system may need to modified (e.g., use of fewer target behaviors, move to a less complex time-sampling procedure) to ensure that the data are reliably collected. At the time of the on-site tour of LSSLC, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals. The data system at LSSLC did not include the collection of data regarding replacement behaviors. The establishment of replacement behaviors is an important component of an effective Positive Behavior Support Plan (PBSP). There was, however, no way to determine if replacement behaviors were exhibited by individuals at LSSLC, because they were not included in any of the data sheets examined by the monitoring team. It is recommended that replacement behaviors be added to each individual's data sheet. All PBSP target behaviors at LSSLC were graphed monthly. That is, each datum point represented one month of data. Some target and replacement behaviors, however, need to be graphed more frequently to ensure sufficient data-based decision-making. For example the monitoring team observed a psychiatry clinic in which a precipitous increase in disruptive and potentially dangerous behaviors was reported for Individual #119. The psychologist was requesting that the psychiatrist review the case to determine if medication could help reduce the frequency and intensity of these dangerous behaviors. Since this change in behavior occurred in the previous few weeks, the monthly graphed data did not completely reflect this individual's sudden change in behavior. If the psychologist had graphed data showing Individual #119's daily behavior, the psychiatrist would likely have better understood how quickly the behavior changed, and could have better evaluated whether it had stabilized or had continued to increase. Additionally, daily graphed data would provide the psychiatrist, and the entire treatment	

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		team, a better opportunity to evaluate the effect of the medication, thereby increasing the likelihood that Individual #119 received the most efficient medication and dosage. Monthly notes documenting the progress of target behaviors were completed for each individual with a PBSP. None of the monthly notes, however, documented the progress of replacement behaviors. It is recommended that monthly notes include both PBSP behaviors targeted to decrease, as well as desirable behaviors (i.e., replacement behaviors). Review of the monthly progress notes of 25 PBSPs revealed that the majority of objectives showed either no progress or an <u>increase</u> in the undesirable target behavior (22 of the 28 objectives reviewed with at least six months of data reported). Despite this apparent lack of progress of the majority of PBSPs, the monitoring team could find no evidence that any PBSP was modified or reviewed prior to its annual review. It is important when individuals' data trends in an undesirable direction that hypotheses be developed, perhaps requiring the redoing of the functional assessment (see section K5 for additional comments on the use of functional assessments), and that modifications to the PBSP occur immediately (rather than waiting until the annual PBSP review).	
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.	<u>Psychological Assessments</u> LSSLC was transitioning to a new psychological evaluation format that included a personal history, standardized cognitive assessment (e.g., Wechsler Adult Intelligence Scale- Third Edition, Stanford-Binet V), standardized assessment of adaptive ability (e.g., Vineland Adaptive Behavior Scales, Social Performance Survey Schedule, Matson Evaluation of Social Skills for Individuals with Severe Retardation), a screening for psychopathology (e.g., Assessment for Dual Diagnosis, Reiss Screen for Maladaptive Behavior) and emotional/behavioral issues (i.e., functional assessment, Questions about Behavioral Function), and an assessment of each individual's medical status. Of the 21 intellectual evaluations reviewed, however, only two used the above format. The other 19 psychological assessments reviewed used a variety of formats. Twelve of the evaluations contained a personal history, six contained an assessment or review of medical status, 15 a screening or review of psychopathology, emotional and/or behavioral issues, and 18 evaluations included reviews or assessment of intellectual and cognitive ability. The facility needs to use consistent psychological assessment procedure across all individuals served. Each individual's evaluation should contain, at minimum: • Standardized assessment or review of intellectual and cognitive ability • Standardized assessment of adaptive ability • Screening for psychopathology, emotional, and behavioral issues	

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		• Assessment or review of biological, physical, and medical status • Review of personal history <u>Functional Assessments</u> All of the 25 PBSPs reviewed referred to functional assessment results. The instrument used to conduct the functional assessments, however, varied. The majority of the functional assessments reviewed (13 of 25) reported using an instrument referred to as the Functional Behavior Assessment Tool. Four of the functional assessments reviewed indicated that the results were obtained by using the Functional Analysis Screening Tool (FAST). Four other assessments used the Questions About Behavioral Function (QABF) tool to identify potential functions of targeted behavior. Finally PBSPs for four individuals (Individual #556, Individual #57, Individual #426, Individual #166) reported information from a functional assessment, but there was no indication what tool or procedures were used to generate those results. All of these assessment tools contained some important elements of an effective functional assessment. The Functional Behavior Assessment, for example, consisted of 13 questions designed to ask of staff or caregivers who are familiar with the individual. The questions covered the following topics: • The frequency and duration of the undesired behavior • Identification of antecedents relevant to the undesired behavior • Identification of setting events relevant to the undesired behavior • Identification of consequences relevant to the undesired behavior • Identification of functions relevant to the undesirable behavior • Identification of psychoactive medications and psychiatric diagnosis if any • Identification of preferences and reinforcers Comprehensive interviews, like the Functional Behavior Assessment are an important component of an effective functional assessment. The QABF and FAST are also examples of interview techniques designed to reveal the potential sources of motivation or function of the undesired behavior. Interviews alone, however, are not generally accepted as constituting a complete functional assessment. A complete functional assessment needs to include direct observation of the target behaviors (and data collection with graphic presentation) in addition to indirect measures. Only one functional assessment indicated direct observation (Individual #99) and it only indicated that Individual #99's behavior was observed, not if the specific target behaviors were observed, recorded, and analyzed. Ideally the indirect component of a functional assessment (i.e., interviews of DCPs such as the Functional Behavior Assessment, or behavior rating scales such as the FAST or QABF) would reveal some	

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		common themes that then can lead to working hypotheses concerning the variable or variables potentially affecting an individual's target behaviors. These hypotheses could then be further refined (or abandoned) based on the results of direct components of the functional assessment (i.e., direct data collection). If the behavior analyst is confident that indirect and direct measures have suggested clear sources of control of the targeted behavior, then the functional assessment is complete, and the results of the assessment can be used to develop the PBSP. If the results of the functional assessment remain unclear, or the PBSP is not producing the desired results, the behavior analyst should then attempt to use other assessment tools, such as a functional analysis (i.e., experimental investigation of variables affecting the target behavior) to better understand the variables affecting the target behavior. In addressing complex behavior problems, functional assessments are often revised several times. The psychologist should also explore other possible contributors to a lack of effective outcome, such as poor fidelity of treatment implementation or absence of integration of psychiatry services. Even so, there was no evidence that the functional assessments at LSSLC were revised when the individual's behavior failed to meet treatment expectations. The functional assessments reviewed attempted to differentiate between learned and biologically based behaviors, identified antecedents and consequences hypothesized to be relevant to the undesired behavior, and identified replacement behaviors. Preferences were identified in 20 of the 25 PBSPs reviewed, however, it was not clear how these items or activities were determined to be preferences for each individual, or if they actually functioned as reinforcers. It is sometimes necessary to conduct systematic preference and reinforcement assessments to identify the most potent reinforcers for each individual. The above discussion focused on the components and processes of an effective functional assessment. The most important characteristic of a functional assessment, however, is its usefulness for developing an effective PBSP. In other words, a useful functional assessment identifies the important antecedents and consequences relevant to the target behavior. It also identifies the most salient setting events and each individual's most potent reinforcers. This knowledge of the undesired behavior is then used to develop the PBSP which should include interventions and replacement behaviors based on the results of the functional assessment. The ultimate test of the effectiveness of the functional assessment is a change in the targeted (i.e., undesired and replacement) behavior. The monitoring team found the majority of functional assessments reviewed (24 of 25) to <u>not</u> be useful in developing an effective PBSP. Many functional assessments identified variables affecting the target behaviors in poorly defined and subjective terms	

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		that would not be useful to the development of an effective PBSP that DCPs could implement with integrity. For example: • Individual #444's functional assessment concluded that her target behaviors were a function of her physical health and mental status. These ecological variables clearly can have an effect on behavior, however, simply stating these subjective states as a function of undesirable behavior does not result in specific treatment interventions that can be implemented by DCPs. This was an example requiring additional assessment to operationally describe the settings, behaviors, and conditions associated with these states. • Individual #333's functional assessment stated that an antecedent of her undesirable behaviors was her feeling staff were not paying attention to her or feeling that others were going to take her possessions. Further assessment was necessary to identify the conditions under which she felt these things. • Individual #305's functional assessment concluded that he became physically aggressive when he was frustrated. The identification of frustration as the explanation of a behavior was not a useful conclusion because, in order to change the behavior, one now needed to know what made the individual frustrated. Until the antecedents and consequences affecting his frustration are understood, one cannot write a PBSP that can effectively address Individual #305's undesirable behavior. • Similarly, Individual #39's functional assessment concluded that he "reacts this way in response to delusional ideation, simple compulsions, sexual impulses...." This type of conclusion was not helpful in developing a useful PBSP. The monitoring team also found the conclusions of many functional assessments to be very general and therefore not useful to the development of an effective PBSP. For example: • Individual #99's functional assessment indicated that his self-injurious behavior (SIB) was maintained by staff attention, tangible objects, and non-social (automatic) variables. This conclusion was so broad that it could not lend itself to any specific interventions. A more extensive assessment to identify more specific antecedent and/or consequence events that were related to the target behavior is required before Individual #99's functional assessment can be useful in designing an effective behavior change plan. • Individual #426's functional assessment indicated that his target behaviors were most likely to occur when he was bored, hungry, delusional, constipated, or seeking staff attention.	

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		There is a large literature describing how to conduct effective functional analyses. This will, however, require the oversight of a competent and experienced behavior analyst. It will also require the development of standard policies and protocols regarding functional assessment and functional analysis procedures.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The psychological assessments for the 21 individuals reviewed at LSSLC were not based on current, accurate, and complete clinical and behavioral data (see sections K5 and K7).	
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.	Psychological assessments at LSSLC were not conducted as often as needed for each individual. Five of the 21 psychological assessments reviewed were conducted within the last 12 months. All of these assessments, however, reported intellectual testing that was conducted from 10 (Individual #99) to 37 years (Individual #593) ago. Three psychological assessments reviewed were two to nine years old, nine were 10-20 years old, and four were 20 to 30 years old. LSSLC should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility. Additionally, the monitoring team recommends that each individual at the facility receive an annual psychological assessment update. The purpose of the annual update would be to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update would comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. The Settlement Agreement requires that psychological assessments are conducted within 30 days of admission. The psychology department list of dates of intellectual assessments indicated that of the last five admissions (Individual #147, Individual #166, Individual #113, Individual #568, and Individual #221) none had psychological assessments within 30 days of admission.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing	At the time of the on-site tour, five individuals participated in counseling services at LSSLC. These services were provided by psychology staff. It was not, however, apparent why these particular individuals received these services, and if the services were goal	

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	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.	directed with measureable objectives and treatment expectations. Subsequent monitoring team on-site tours will closely review these services to ensure that they are identified as a need in each individual's psychological assessment, that the services reflect evidence-based practices, and that the services include documentation and review of progress.	
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.	Twenty-five PBSPs at LSSLC were reviewed to assess compliance with this provision. All of the PBSPs reviewed had the necessary consents and approvals. The monitoring team noted that there were several formats used to write PBSPs at LSSLC. All the formats contained many of the necessary components of a PBSP commonly accepted in applied behavior analysis. These included: • History of prior intervention strategies and outcomes. • Consideration of medical, psychiatric and healthcare issues. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors. • Description of potential function(s) of behavior. • Treatment expectations and timeframes written in objective, observable, and measureable terms. • Strategies addressing setting event and motivating operation issues. • Strategies addressing antecedent issues. • Strategies that include the teaching of desired replacement behaviors. • Strategies to weaken undesired behavior. • Description of data collection procedures. • Baseline or comparison data. • Signature of individual responsible for developing the PBSP. On the other hand few of the PBSPs reviewed contained the following necessary components of a PBSP: • Rationale for selection of the proposed intervention. • Use of positive reinforcement sufficient for strengthening desired behavior. • Clear, simple, precise interventions for responding to the behavior when it occurs. • Plan, or considerations, to reduce intensity of intervention, if applicable. LSSLC should use one consistent format for PBSPs, and ensure that all of the above components are included in each individual's PBSP. It is very important to note that the quality of many of the components that were	

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		included in the PBSPs, however, was often inadequate. For example, although all of the programs reviewed included descriptions of potential functions of target behaviors, the thoroughness and usefulness of these descriptions for understanding and ultimately changing behavior was generally inadequate (as discussed in section K4). Additionally many of the operational definitions of the replacement behaviors were unclear to the monitoring team and not likely to be clear to DCPs attempting to increase them. For example, one of Individual #333's replacement behaviors was obtaining preferences appropriately. It was defined as "obtaining her preferences according to the Behavior Supports in this Positive Behavior Support Plan without becoming physically aggressive…" This definition did not reflect clear and objective behaviors that staff could easily follow to increase this behavior. Another similar example involved one of Individual #166's replacement behaviors. The behavior was defined as seeking attention from others without drawing negative attention to self. Although this represented an example of a strategy for teaching a replacement behavior, without additional information it was unlikely that any staff could increase this behavior from this description. Specific skill acquisition plans should be reliably implemented for replacement behaviors. Moreover, these plans should not be treated differently than other skill acquisition plans and, therefore, should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 below for a more complete review and discussion on the use of skill acquisition plans at LSSLC). Many of the weaknesses associated with the PBSPs were the direct result of the inadequacy of the functional assessments (as discussed in section K4), and the relative independence between the functional assessment results and the PBSP interventions. Moreover, when the interventions were not based on a clear understanding of the target behavior, they often tended to be general and generic. For example, Individual #333's PBSP specified the following general intervention to address her SIB: 1. If Individual #333 is throwing objects, make sure others in the area are protected from injury and redirect them from the area if there is a chance they will be injured. 2. Attempt to problem solve with Individual #333 to find out what is wrong. 3. Ask Individual #333 if she would like to go to her room for some quiet time. Offer her other activities once in her room. Interventions that are not based on results of a functional assessment not only tend to be	

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		general, they often lack individualization. For example, the intervention for decreasing Individual #517's physical aggression looked very similar to Individual #593's intervention to decrease SIB. Both PBSPs included the following interventions: 1. Environmental engineering 2. Structured scheduled activities 3. Offer choices 4. Enriched environment Finally, interventions that are not based on functional assessment results tend to be unclear, complicated, and imprecise. For example, Individual #41's intervention to address temper tantrums stated: "Catch Individual #41 early in the sequence and encourage calming. If Individual#41 becomes upset, then it is up to him to calm himself. Please simply allow him to calm down, but separate others from Individual #41 in order to protect them. Protect Individual #41 by blocking his blows." These general and imprecise interventions could also result in an increase in undesired behaviors. For example, Individual #99's intervention to decrease flight (i.e., unauthorized elopement from the home) included: • Provide the level of supervision set by the PBSP • Remind him that you must see him at all times • If he attempts to leave supervision, follow him and use PMAB procedures to maintain his safety The monitoring team observed Individual #99 in his home unit. When he began to run through the home unit, the DCP assigned to him ran with him attempting to distract him. The DCP successfully prevented Individual #99 from eloping from the home unit. It appeared to the monitoring team, however, that her running with him was very reinforcing to Individual #99. If the hypothesis based on this brief observation was correct, then one would expect that Individual #99's running on the unit (and therefore increasing the likelihood of running off the unit) will increase in the presence of this DCP (and any other DCPs who interpret the PBSP in this way). The DCP was responding in a manner that was consistent with Individual #99's PBSP, however the general nature of the plan resulted in the staff implementing their own interventions based upon their interpretation of the written plan and, in this case and likely in other cases, were likely to result in an increase in the undesired behavior. The interventions in many PBSPs reviewed at LSSLC appeared to be contraindicated by the functional assessment results. For example: • Individual #134's functional assessment hypothesized that his physical	

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		aggression was maintained by escaping demands. His intervention to decrease physical aggression, however, stated that staff should reduce demands if he began to engage in the target behavior. If the conclusions of the functional assessment were correct, this intervention would result in an increase in the undesired behavior. • Similarly, Individual #245's functional assessment suggested that her physical aggression occurred because it allowed her to escape or avoid unpleasant activities. Her PBSP specified that if she was aggressive, to provide a calm verbal prompt. If she appeared inconsolable, however, change her environment by taking her on a short walk or on to the porch thereby removing her from an unpleasant activity and thereby reinforcing the problem behavior, making it more likely to occur in the future. Another common characteristic of the 25 PBSPs reviewed at LSSLC, was the absence of obvious potent consequences for behavior, specifically the systematic, planned use of positive reinforcement. Although some PBSPs specified providing praise and, in some cases, tangible items for the absence of target behaviors, in most of the PBSPs, neither staff attention nor access to the tangible item was reported to be a reinforcer for the individual. The use of positive reinforcement is a generally accepted professional standard of care in the treatment of individuals with developmental disabilities. There is a tremendous amount of published research in the literature demonstrating its effectiveness for this population and, further, its use is in line with the intent of this provision K of the Settlement Agreement. To illustrate: the monitoring team found no evidence of token or point systems or contingent reinforcement with tangible items. Changing and improving individual behavior across every unit at LSSLC will be difficult, if not impossible, without the planned, thoughtful use of positive reinforcement. The use of positive reinforcement, such as the earning of special privileges or items (and thereby the potential failure of an individual to earn these privileges or items), should not be viewed as competing with the facility's (and the state's) goal of having positive behavior support plans. The monitoring team hopes that the facility will embrace the many well-researched applications of positive reinforcement contingencies. The psychologists who develop and manage the PBSPs should have the opportunity to program the most potent reinforcers available to encourage desirable behaviors and to discourage dangerous and undesirable behaviors in the individuals they serve. Access to more potent reinforcers is not a substitute for incomplete functional assessments or PBSPs, however, the inclusion of the most potent reinforcers for desired behaviors is not only a best practice in ABA, it would likely enhance the effectiveness of a well written, function-based plan. Psychology staff will need the support of senior administration at	

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		LSSLC in order to successfully incorporate the use of positive reinforcement contingencies into their PBSPs. The monitoring team reviewed PBSPs that appeared to contain the majority of the components of a PBSP presented above and, most importantly, resulted in meaningful changes in individual behavior. One example was found; it was for Individual #369. A functional assessment revealed that Individual #369's SIB (thumb biting) was maintained by the staff attention she received when she bit herself. The replacement behavior consisted of teaching Individual #369 to ring a hand bell or activate a switch plate to receive staff attention. The antecedent procedure specified that staff should provide enthusiastic attention to Individual #369 whenever she rang her bell or at anytime that she was not engaging in SIB. The intervention for SIB consisted of blocking biting (while keeping staff attention to a minimum). Further, data reviewed revealed that Individual #369 had reduced her bite attempts from 12 in January 2010 to 1 in February 2010. This provided an example of how interventions based on the results of a thorough functional assessment can result in important changes in behavior.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	There was no evidence from observation or staff interviews that inter-observer agreement measures existed for PBSP data at LSSLC. Having a system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment. PBSP data were consistently graphed monthly at LSSLC. As discussed in K4, however, these data should be graphed and presented in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors). These graphs should include horizontal and vertical axes and labels, condition change lines and label, data points, a data path, and clear demarcation of changes in medication, health status, or other relevant events. Documentation at LSSLC was not done in a manner that allowed for a determination of whether progress was occurring or if treatment was implemented correctly. This then made it difficult for the data to be used for review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	
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	All direct care professionals (DCPs) interviewed indicated that they understood each individual's PBSP. When asked to explain how they would respond to specific target behaviors, they typically responded with general interventions that were consistent with the written plans that contained somewhat overly generic types of interventions (see discussion in K9).	

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	be understood and implemented by direct care staff.	The best example of a PBSP being implemented with integrity at LSSLC was found during a tour of one of the residences. The monitoring team asked the DCP working with Individual #192 to explain what she did if Individual #192 attempted to hit her head. The staff correctly responded that she would block the SIB, and prompt Individual #192 to put her hands down. The DCP was also able to describe the helmet fading procedure and the correct times for helmet removal and replacement. On the other hand, while the DCP working with Individual #460 was able to describe the blocking component of Individual #460's plan, she did not describe the time-out procedure specified in Individual #460's plan. The only way to ensure that DCPs can, and do, consistently implement PBSPs as written, is to establish and implement a systematic treatment integrity assessment tool. This tool would allow psychologists writing the plans to assess if each DCP is implementing the PBSP correctly as written. It would also provide the psychologist with a methodology to train, and re-train as needed, each DCP who will interact with that individual. There was no evidence that LSSLC implemented a system to monitor and ensure treatment integrity.	
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.	LSSLC did not maintain training logs that reflected if DCPs had received training on individual PBSPs. Each psychologist, however, maintained inservice sheets documenting the training of each staff on each individual's PBSP. Each psychologist conducted monthly training, but no standard training methodology had been adopted by the department. One psychologist had developed a pilot staff training program that may serve as a model for the department. Her training consisted of didactic training of material (or a PBSP), followed by written questions, and re-testing until each staff achieved competence. The training also involved a competency-based component whereby staff watched videos of staff engaging in various target behaviors, and staff recorded their behavior by completing standard data sheets. It was not clear how follow-up on staff training occurred and how needed training was tracked. It is recommended that the facility develop a more coordinated system to ensure that all staff (including floated staff) are trained in the implementation of each individual's PBSP. It is also recommended that the facility identify a standard methodology for staff training that includes a combination of didactic, modeled, and in vivo strategies. Finally it is recommended that the facility establish an integrity assessment to determine the extent that staff implement the PBSPs as intended.	
K13	Commencing within six months of the Effective Date hereof and with	The psychology department employed 14 psychologists and 8 psychology assistants serving 414 individuals.	

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	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.	While the total number of psychology staff and assistants met the ratios required by this provision item for the population served at LSSLC, none of the psychology staff had the training and expertise in applied behavior analysis as noted in section K1 above (i.e., attained certification as a behavior analyst).	

Recommendations:

1. Develop a policy and plan to ensure that all psychologists writing and monitoring PBSPs at LSSLC are competent in applied behavior analysis and obtain board certification for behavior analysis (BCBA).

2. Establish an internal and external peer review system for PBSPs.

3. Develop a consistent methodology for data collection. Ensure that the system is flexible enough to be sensitive to individual needs and is reliable.

4. Regularly collect inter-observer agreement (IOA) data, establish IOA goals, and ensure goals are achieved.

5. Include replacement behaviors in the data collection system.

6. PBSP target and replacement behaviors should be graphed at a frequency sufficient to promote effective decision-making.

7. Monthly progress notes should include the status of replacement behaviors as well as behaviors targeted to decrease.

8. Modifications to the PBSP should reflect data-based decisions, not annual timelines.

9. The facility needs to use consistent psychological assessment procedures. Each individual's evaluation should contain, at minimum:
    - standardized assessment or review of intellectual and cognitive ability
    - standardized assessment of adaptive ability
    - screening for psychopathology, emotional, and behavioral issues
    - assessment or review of biological, physical, and medical status
    - review of personal history

10. Functional assessments should include:
    - a process that includes both direct and indirect measures. Direct assessment techniques should include, at minimum, the collection and analysis of descriptive data (e.g., ABC data)
    - clear differentiation between learned and biologically based behaviors
    - identification of setting events and motivating operations relevant to the undesired behavior

- identification of antecedents relevant to the undesired behavior
- identification of consequences relevant to the undesired behavior
- identification of functions relevant to the undesired behavior

11. Functional assessments need to be revised when an individual's behavior does not meet treatment expectations.

12. Systematic preference assessments should be used when preference surveys do not identify effective reinforcers.

13. Psychological assessments should be completed for every individual residing at LSSLC.

14. Psychological assessments should be based on current, accurate, and complete clinical and behavioral data.

15. Psychological re-assessments should be conducted as often as needed, but at least every five years.

16. Psychological assessments should be conducted within 30 days for newly admitted individuals.

17. Ensure that all individuals receive annual psychological assessment updates.

18. All psychological services provided should be goal directed with measurable objectives and treatment expectations.

19. Use a consistent PBSP format that includes all of the components so that the plan meets current acceptable practice in applied behavior analysis.

20. Ensure that PBSPs are based on functional assessment results.

21. Specific skill acquisition plans should be implemented for all replacement behaviors.

22. PBSPs should include potent consequences for the absence of target behaviors, including contingent positive reinforcement.

23. The facility should implement a treatment integrity system to ensure that PBSPs are understood and implemented as intended.

24. Develop a standard staff training methodology that includes a combination of didactic, modeled, and in vivo strategies.

25. Develop a system to ensure that all staff are trained prior to implementation, and throughout the duration, of each individual's PBSP.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Requirements of the separate monitoring plan, identified as the Health Care Guidelines o Curriculum Vitae of the full-time physicians in the medical department • Dr. Carlin, Dr. Corley, Dr. Odero, Dr. Chang o Requirements of the separate monitoring plan, identified as the Health Care Guidelines o The policy and procedure manual for the LSSLC Medical Department o Various protocols for disease state management o Annual and initial medical monitor lists o Death reviews on the following individuals: • Individual #372, Individual #486, Individual #338, Individual #559, Individual #493, Individual #483, Individual #69, Individual #8, Individual #30, Individual #173, Individual #472 o The following documents: • Adult Preventative Care flow sheet (if present) • Labs, EKG, radiology reports over the past year • Past three months of progress notes • Past six months of restraint and injury reports • For these individuals: ▪ Individual #113, Individual #306, Individual #119, Individual #532, Individual #147, Individual #321, Individual #106, Individual #31, Individual #344,Individual #423, Individual #488, Individual #180, Individual #203,Individual #367, Individual #9, Individual #569, Individual #480, Individual #116, Individual #169, Individual #90, Individual #54 Interviews and Meetings Held: o Dr. Carlin, Medical Director, for review of policy and procedures o Dr. Chang and Dr. Carlin regarding death review o Daily meetings with Dr. Carlin, the medical director o Three meetings with Dr. Julie Moy, DADS central office medical director o Gale Wasson, facility director Observations Conducted: o Medical morning meeting with all four medical staff o Medical rounds o Walking rounds with medical director of 559 A and B and 557 A and B o Medication Error meeting

	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Medical care was overseen at the facility by four physicians, three of whom were board certified in their specialties of orthopedics, family medicine, and internal medicine. The fourth physician did not appear to have board certification in any specific field but had six years of post-graduate medical specialty training in the United States. A nurse practitioner began work at the facility during the week of this baseline onsite visit. The physicians had a strong attitude of care and concern for the individuals at LSSLC. The facility maintained a busy infirmary onsite where individuals that needed more medical monitoring were able to have round the clock nursing care. Until the first of the year, the medical director was the only physician to take call. He had been at the facility on holidays, took little to none of his earned vacation leave, and was very dedicated to the individuals at LSSLC. Each primary care physician at the facility had a separate caseload for which he was responsible. This included providing the preventative and "sick call" care for each individual. Each physician monitored his own labs, x-rays, EKGs, and outside consults. Call was now shared, but each physician frequently came in on his days off to see individuals on his caseload who were sick, including on many weekends. The orthopedic physician also saw all orthopedic problems, employee injuries, and oversaw orthopedic surgery cases that were on other physician's caseloads. He read all orthopedic x-rays in the facility. Policy and procedures for the department were in development. The current medical director worked on numerous flow sheets for various commonly occurring conditions. The DADS central office was developing more policies and procedures in order for the medical department to be able to meet the Settlement Agreement provisions.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with	The state policy for this provision was not yet developed or in place. It is expected that the policy will provide guidance to the facility regarding this provision. In the absence of a formal policy, the medical director devised a preventative care flow sheet that was complete for the records of his individuals (of those reviewed by the monitoring team). The other physicians did not utilize this tool. At LSSLC, there was no formal annual medical summary document. Instead, it was contained under the medical	

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	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.	section in the PSP or PBSP. Additionally, there were some records that did not have an annual medical summary noted in either the PBSP or PSP. The records of the following individuals had no annual medical summaries: • Individual #180, Individual #488, Individual #106, Individual #31 The death review of Individual #69 was noteworthy because of the fact that the CT of the brain showed a chronic and acute subdural hematoma with herniation of the brain. The physician in charge of her care had ordered skull films after a head injury sustained in July 2009. She also had an injury that resulted in fracture of her femur in March 2009 and records with information of events occurring at the time surrounding that injury could not be located at the time of this baseline onsite visit. The monitoring team was concerned about whether or not she had head injuries that went without an adequate workup prior to her death in October 2009. When questioned about why skull films were ordered, but not a CT scan, the physician in charge of her care could not give an answer. This same physician was noted to have ordered a HGA1c on individual #119 on 9/4/09 of 7.6 without any follow-up diabetic diet orders or subsequent repeat A1c orders until 12/16/09. This individual was also followed by one of the psychiatric providers. When he requested an intervention about the A1c, he was told by the physician to not be concerned about it. Medical problem lists were missing or not up to date in the following records that were reviewed: • Individual #180, #367, and #203. Labs, EKGs, and radiology reports were not always signed and rarely were they commented on or written into a progress note. One of the death reviews (Individual #372) had a comment from the reviewers that "physicians need to address positive results." • Cardiology consultation was to be obtained for all individuals over the age of 60 beginning with June 2009 physicals. The individual had died of an acute MI and on autopsy there was evidence of an old infarct. • In the record reviews, Individual #9 had evidence of "an old inferior infarct" on the EKG obtained 9/29/09, but there is no comment on the EKG itself or within the record as to whether or not the attending physician concurred with the result. • Individual #31 also had an EKG that was read as abnormal, but had no comment by the attending physician. • Individual #90 had an EKG that was recorded as LVH, but not confirmed or commented upon in the record by the attending physician. • Individual #31 had hypercholesterolemia on "double therapy" (Zeta and Lipitor)	

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		noted as an active problem, but no lipid levels had been drawn in the past year. This was not in line with the healthcare guidelines.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	At the time of the baseline onsite review, there was no non-facility physician case review.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	At the time of the onsite baseline visit, there was no formal quality improvement process in effect at LSSLC for collecting data related to the quality of medical services. The medical director will need guidance from the central office on tracking and trending of certain disease states that may be endemic to this area or facility. The facility will have great difficulty with such quality improvement projects until an EMR is established that will allow for tracking of data.	
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.	At the time of the baseline review, the standards for provision of medical care were in development. This provision item refers to the Health Care Guidelines, a detailed set of guidelines for medical care. Even though these applicable standards had been chosen by the parties, a policy had not yet been developed regarding implementation of these guidelines. It is expected that a new policy along with specific procedures will be required by the facility if it is to meet these standards and this provision item.	

Recommendations:

1. The tool that the medical director has developed should be used for tracking the preventative care of each individual in order to ensure that every individual is receiving proper preventative care. The policy needs to include a provision for physician discretion to override such policy in the interest of any particular individual. In particular, invasive procedures, such as colonoscopy, should be at the physician's discretion as to the appropriateness for any given individual for whom they are attending.

2. Develop and implement policy and procedures. It has been recommended that these come from the central DADS office. This would eliminate valuable physician time writing such policies. Policies could be individualized in each facility as needed.

3. Admission and discharge criteria for the infirmary need to be written as part of the policy development at this facility.

4. Review of and tracking the labs for psychotropic monitoring should be the responsibility of psychiatry with appropriate referral and follow- up by primary care. An example is that if lipids or HgbA1c are elevated in an individual receiving second-generation antipsychotics, then collaboration with the primary care provider is appropriate. Psychiatry should have primary responsibility for commenting on the lab and the need for consultations or changes in the treatment plan.

5. All abnormal results need signature and comment within the record. In the El Paso SSLC this was accomplished with a stamp on each result, which also had an area for comment. This prompted the practitioner to comment on the result as well as sign it. It is common for physicians to review labs without the record; this would accommodate for them to comment on the lab slip and then have it placed in the record. It is clear from the death review cited in L1 that there was a positive result that went without comment.

6. The medical staff needs a weekly meeting with the facility director as also discussed in section J above. There were a host of complaints that came from physician providers of which the facility director seemed unaware. For example, there needed to be discussion and agreement regarding the use of medical and physical restraints, especially when needed to prevent injury and ensure safety of individuals. At the suggestion of the monitoring team, a meeting was initiated immediately (it occurred during the week of the onsite visit) and was well received by all participants. Physicians need to be fully included in the team process because they are ultimately liable for the medical and health care that is delivered by the entire team. In order for this to occur, the administrative leadership needs to be on the same page with physician leadership.

7. Annual medical summaries should be included on all individuals in the facility.

8. A full-time administrative staff member is needed for the medical department. This person should not be involved with running specialty clinics or other duties. The staff member can be a valuable asset by working on tracking, trending, and other administrative and clerical duties required by the provisions of the Settlement Agreement. Quality improvement processes will also require administrative time in order to generate reports.

9. Medical and psychiatry need to integrate and coordinate care. The medical director's attendance at clinic is a start in this direction. Once the facility has full-time psychiatry staff, it would be in the best interest of the individuals if the disciplines could meet to discuss complex cases on a regular basis.

10. Medical staff need to have access to neurology more than only monthly. Many individuals at the facility had seizures and it appeared from the review of the records, that primary care had a great deal of responsibility for treating seizures.

11. All primary care providers need to have full access to psychiatry for emergency purposes so that they are not in the position of caring for acute psychiatric problems. This will improve as full-time psychiatry staff are added to the facility.

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 Dental Sedation, 7/09 to 2/10 o ER visits, 7/5/09 to 3/12/10 o Health Status Team Procedure, dated 10/16/09 o Hospitalizations, 3/3/09 to 3/14/10 o Individuals with Most Injuries, 7/1/09 to 2/4/10 o Infection Control Manual Revision/Update, 1/2010 o Infirmary Admissions, 7/1/09 to 3/18/10 o Medical Sedation, 9/09 to 2/10 o Medication Administration Policies and Procedures, reviewed 2/09 o Medication Error Reports by Unit, by Department o Medication Error bi-weekly Meeting notes, 4/7/10 o Medication Error bi-weekly Meeting Notes, 9/23/09 to 2/26/10 o Medication Error Reports, 2/1/10 to 3/5/10 o Medication Excess Shortage Forms o Medication Station Nursing Audit forms o Monthly Infection Tracking, 7/09 to 1/10 o Five sets of MARs from list of requested records where dosages of medications were in multiple forms o Nursing Orientation-Agency Nurses, undated o Nurse Manager Monthly Audit Form o Overage, Shortage forms for 4/1/10 to 4/14/10, for all shifts and all buildings o Pharmacy and Therapeutics Committee Meeting, dated 7/15/09 (only recorded date) o Pneumonia Diagnoses from 3/5/09 to 2/22/10 o Positioning Audit for G-tubes/J-tubes-POI M-5-6 form o Quality Enhancement Meeting Notes, dated 4/21/10 o Risk Lists, High, Medium, Low, dated 3/16/10 o Safety and Health Council Minutes, 7/22/09 to 3/17/10 o Sedation Pre-Treatment and Post Sedation Monitoring Policy and Monitoring Forms o Weekly Nursing Meeting Minutes, 9/23/09 to 3/09/10 o Controlled Drugs Accountability Policy, dated 12/09, original 3/89 o Nursing Services Policy, dated 01/10 o Nursing Competency Based Training Curriculum, dated August 2009 o Health Status List as of 3/16/2010: High, Medium, Low o Documents from the records for each individual in the sample: • Most recent quarterly pharmacy review • Demographic information sheet

	• Most recent medical summary • Most recent nutritional assessment • Integrated Progress Notes from 2/10 through 4/10 • Active Acute Care Plans (ACPs), Medical Care Plans, and Health Management Plans • Adult Care Flow Sheet • Active/Inactive Problem Lists • Recent Seizure Records for last 12 months for Individuals on seizure lists • Nursing "H" sheets for Health Management Plan Reviews for 1/10 through 3/10 o Individuals in sample and characteristics/conditions: • Individual #147: Hospitalization/Acute Care; Psych; Respiratory; Weight Loss • Individual #288: GI; Hospitalization/Acute Care; Respiratory • Individual #321: GI; Hospitalization/Acute Care; Respiratory • Individual #540: Chronic Care • Individual #160: Aging; Diabetes; Diabetes Mellitus; GI; Psychiatric • Individual #36: Chronic Care; Respiratory; Skin Integrity; • Individual #586: Hospital/Acute Care; Skin Integrity • Individual #269: Psychiatric; Restraints • Individual #257: Pain; Preventive Care • Individual #444: Aging; Diabetes; GI; • Individual #513: Aging; GI; Seizures • Individual #211: GI; Pain; Seizures • Individual #457: psychotropics; weight loss; Preventive; Seizures • Individual #223: Chronic Care, Hospitalization/Acute Care • Individual #165: Pain • Individual #560: Aging, Seizure, Skin Integrity • Individual #424: Hosp/Acute Care; Respiratory • Individual #141: Hospitalization/Acute Care; Respiratory; Seizures; Weight Loss • Individual #387: Diabetes; Respiratory; Seizures; Weight Loss • Individual #124: GI; Preventative, Psychotropics • Individual #298 • Individual #500: Medication Pass • Individual #524: Medication Pass • Individual #138: Medication Pass • Individual #208: Medication Pass • Individual #203: Medication Pass • Individual #126: Medication Pass <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Mary Bowers o Nursing Operations Officer: Laura Flowers

	o Quality Enhancement Nurse, Gena Hanner o Nurse Managers o Nurse Hospital Liaison, Janet Montes o Infection control nurse, Murleen Beaird o Nurse Educator, Wayne Durham o David Leeves, Director of Pharmacy o Abimbola Farinde, Pharm.D. o Dr. Louis Kavetski, facility dentist, and his staff <u>Observations Conducted</u>: o Weekly Nurses meeting o Quality Enhancement meeting o Medication Error meeting
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Mary Bowers, Chief Nurse Executive for LSSLC was in her position for a little over a year. She had the following management staff reporting to her: • Nursing Operations Officer: Laura Flowers • Infection Control: Murleen Beaird and Hannah Moore • Nurse Educator: Wayne Durham and Zalinda Colston • Hospital Liaison: Janet Montes Ms. Bowers had previously been in the position in 2005 and 2006. At that time, there were only eight nurse case managers. She went to DADS regulatory for 18 months, returned to LSSLC into the Nursing Operations Officer position for a short time, and then moved into the CNE position in the last 12 months. There had been a large infusion of Nurse II positions in the last year or so, and the facility was able to hire a nurse recruiter in order to fill these jobs. There was also an increase in shift differential in November and these two factors influenced staffing to the point where there was a 90% fill rate at the time of the on-site monitoring visit. Nurse IV positions represented supervisory positions. There was about to be (by 5/1/10) five nursing supervisory positions on the evening shift. There were 23 nurse case managers at the time of the onsite baseline tour, with one additional person on maternity leave. Staffing in the nursing department included 139 total positions. The Nursing Operations Officer, Infection Control Nurse, Nurse Hospital Liaison, and Nurse Recruiter reported directly to the CNE. Nurse managers and Nursing Education reported to the Nursing Operations Officer. Staff numbers included three respiratory therapists who worked Monday through Friday from 6:00 am to 10:00 pm.

	LVNs provided respiratory treatments after hours and weekends. There were five Nurse Managers. Nurse Case Manager and direct care RNs were reporting to the Nurse Manager for their assigned area. The 2:00 pm to 10:00 pm nursing shift supervisors were responsible for the LVNs on the evening shift. Since the new nursing positions were restricted to RNIIs, and the Certified Medication Aide Positions were eliminated, the nursing department staff had been forced into two actions. First, RNIIs were required to administer medications, even though these positions were intended to support the Nurse Case Managers. Second, agency LVN nurses were used to fill in for medication administration positions that could not be filled due to shortage of staff since the elimination of 10 to 12 CMA positions. RNs working days were administering medications. The Infirmary consisted of a unit with an 18-bed capacity. The census included two individuals whose parents, according to nursing staff, would not allow the facility to move them onto the homes. The census on the first day of the onsite monitoring tour was 15 individuals, including these two permanent infirmary residents. Salaries for nursing positions were competitive, particularly since the evening shift positions received a 15% shift differential. The staff recruiter was able to recruit experienced RNs from acute facilities in town. More nursing staff, however, were needed; it would require approximately 20 LVN positions to cover slots currently covered by agency staff. LSSLC had a mandated curriculum and provided orientation to new nurses. Agency nurses were mentored the same amount of time as LSSLC nurses with required competencies checked off before the agency nurse was allowed to function independently on the living units. There had been an increase in the number of DADS standardized nursing policies over the past year. Even so, LSSLC created and maintained a lot of their own nursing policies, according to the CNE. Most of the DADS policies were presented to nursing staff in August and September of 2009 and implemented in October 2009. The facility had only just begun developing systems to monitor compliance with Settlement Agreement requirements. One of these was the "H Sheets," which was a monthly review of health plans completed by the Nurse Managers on all individuals in their respective areas. These management reviews were entered into the electronic data base allowing the Nursing Operations Officer to also monitor the status of both acute and chronic health management plans. According to the CNE, the following represented some of the challenges to implementation of the Settlement Agreement and Health Care Guidelines: • Maintenance of an adequate level of appropriately trained staff. Training nurses to meet the new

	requirements was described as intense, but carry over into actual nursing practice was described as an even greater challenge. • The need for more nurses, particularly in the LVN category, was critical to the CNE. The facility was using direct care RNs, originally designated to assist the RN case managers, but who were diverted to direct care responsibilities, such as medication and treatment administration responsibilities. • LVNs could only be off duty every third weekend because of limited number of nurses available for weekend staffing. Scheduling was an issue and the CNE noted that she lost a lot of LVNs to other health care facilities that routinely scheduled every other weekend. • Last spring, the facility increased staffing ratios in areas where tube feedings were done. When the CNE came back to the facility in January of 2008, there were only 32 individuals who were tube fed. This number had increased to 55 over the subsequent 18 months. The amount of time required to complete medications and treatments was much higher with these individuals. • Nursing documentation was been a particular challenge. The facility had been using the DAP (Data, Assessment, Plan), and nurses were doing either too much or too little, or not understanding the system at all. This proved to be a very detailed process and a lot of nurses required a lot of time and effort to learn the system. The first annual skill fair was conducted last October with all nurses required to attend with the mission being to demonstrate that they were competent in all the procedures required for their particular job. There will more competencies added this year, including abdominal and respiratory assessment. Every nurse that attended completed a competency exam.

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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.	Also see M2 below. The Nursing Operations Officer position supervised five nurse managers as well as the nursing education department. She also supervised staffing coordinators who ensured adequate staffing on the individual units for three shifts, seven days a week. The NOO participated in most facility processes that impacted on functioning of the individual units, including some of the following: • Infirmary rounds where decisions were made regarding the movement of individuals to and from the hospital and the regular living units. This included deciding what had to be done to get ready to readmit persons to the facility from acute care or infirmary settings. There were different requirements depending on the capacity of the home to receive the individual. Decisions had to be made if an individual required a new and different level of care. This may have required a larger team process if the individual's status had changed such that he or she needed more care than the home unit could provide.	

#	Provision	Assessment of Status	Compliance
		• This position provided nursing crisis management in the facility in terms of staffing, emergencies, and movement of individuals in and out of regular residential settings to the infirmary or acute care. Supplies and staffing for 24 hour management were the priorities of her position. • Management spread sheets allowed the NOO to get a handle on what was occurring in the individual units. The weight management sheet allowed the dietician and the nursing department to monitor weight stability on a monthly basis. Panic values for weight change were set at 5% per month, 7.5% per quarter, and 10% for six months. When these values were exceeded, this issue was to be bumped up to the team, primarily to the Nurse Case Manager to ensure that action was taken. • The Master Tracking list tracked the status of Case Management requirements, such as MOSES and DISCUS, Quarterly and Annual Nursing Assessments, Acute and Chronic Care Plans, or any recurring Nurse Case Manager responsibility. H Sheets had been implemented in the last year and allowed the nurse managers to document the status of all health care plans and other recurring assessment requirements. This tool also tracked the status of Health Management Plan reviews as well as the type of health management plans being managed (e.g., seizures, UTI, Photo sensitivity, poor vision, hypertension). • Acuity levels were increasing as the population aged and experienced more health care issues. Medication and treatment administration responsibilities had been increasing in terms of numbers and complexity, particularly for individuals who were non-ambulatory and fed by other than oral means. Current age range of this population ranged from 7 to 95 years old, with the majority in the upper end of the scale. While the above represented the beginnings of a good system, these efforts have just begun and will take some time to mature. They also tended to look for the presence of documents more than the quality of documents and the quality of procedure implementation.	
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.	There had been a number of administrative actions that were showing promise, such as the master tracking list and the H sheets. These were very new and looked primarily at what had been done, rather than focusing on the quality of the nursing assessments. The monitoring team found no instances where nursing assessments were not complete and present in the files. Further, whenever an acute care plan was required, it was also completed in a timely manner. As noted above in M1, the system should begin to look at the quality of assessments and health care plans rather than just the presence. For the most part, the nursing annual and quarterly assessments were lengthy, accurate, and	

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		comprehensive.	
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.	Basic health care needs were currently addressed in the Acute and Health Management (chronic) Plans. There were Health Management Plans for each chronic problem identified in the nurses' progress notes. These were monitored closely on a document called the "Big Master Tracker" that documented whether the plan was present, along with a number of other items, but did not deal with the comprehensiveness of the Health Management Plan. For example, for many individuals, particularly those with respiratory, GI, and other issues where immobility and alignment issues were problematic, there was little evidence that the specific physical and nutritional management aspects of chronic care were evidenced in their health management plans. Early identification of chronic illness symptomatology was not addressed in the Health Management Plans. Monitoring of these Health Management Plans, however, was done on a monthly basis by nursing, and more frequently as indicated. The facility was providing adequate care for the chronic conditions of diabetes, bowel management, and skin integrity. The facility was not providing adequate care for the chronic conditions of GERD, incontinence, and chronic respiratory illness. These areas of service will need further development. GERD and aspiration are two closely related health care outcomes that demand interdisciplinary collaboration to assure that at risk individuals have positions that prevent the problem from occurring or worsening. GERD often leads to aspiration because the individual is in a position that prevents emptying of the stomach and facilitates reflux. Elevating the head of the bed is often not a functional intervention for a number of reasons. First, the individual should not be in the bed for more than eight to 10 hours at a time. Second, elevating the head of the bed must be combined with assuring the quality of the individual's position. For example, the order should state: "Assure that the individual is elevated at all times to at least 30-45 degrees with the head and trunk in alignment and the nose, naval and knees pointing in the same direction." When sitting, the individual should be positioned with the pelvis in a slight anterior tile, with support to the forearms, such that the head and trunk are elongated, and the head is in neutral or slight capital flexion. There was no evidence that the nurses consistently documented a full head to toe assessment in the presence of signs and symptoms of acute illness and injury. Regarding infection control, staff were trained in hand washing and in standard infection control procedures.	

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		There was an Antibiotic Subcommittee which met monthly and tracked use of antibiotics, type, locus of infection, and response to treatment. The facility had yet to address the risk management issues that would impact on reducing health risk for identified individuals. This was evidenced by: • There were 15 individuals who were seen either in the emergency room or hospitalized with respiratory issues that were either described as aspiration or appeared highly suspicious of aspiration. There were 11 other non-related respiratory issues involving ER/hospitalization. From 3/3/09 until 3/14/10, there were 206 hospitalizations, and from 7/5/09 to 3/12/10, there were 191 ER visits. Respiratory issues were the major cause of hospitalization, many of which were suspected to be aspiration. Only 11 persons, however, were identified to be at high risk for aspiration. • There were eight individuals who required acute care for Urinary Tract Infections, but none were listed at high risk, and eight identified at moderate risk. • Few care plans for persons who were either seen in the ER or admitted to acute care addressed the quality of positioning for intake and/or emptying. • Individual #147 had a Health Management Plan that addressed his risk for aspiration, but it did not mention his need for positioning to prevent aspiration. While it did mention keeping the head of the bed at 30 degrees, the fact is that Individual #147 needed to be positioned 24 hours a day so his head and body were in alignment and elevated to at least 30 degrees, while at the same time, his nose, naval and knees should be pointing in the same direction. When vomiting is about to occur, the individual's head should be pulled toward his chest. • Individuals #288 and Individual #321 had frequent upper respiratory infections with similar risks for aspiration of secretions and risk for GERD. Neither of these individuals had care plans that addressed the issue of positioning related to respiratory risk. • Individual #321 had a nursing intervention requiring the head of his bed to be at 40 degrees, but no other qualitative instructions were provided, and no visual representation was given to assist staff in implementing the position.	
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	Nursing assessment protocols were adequate. Annual and quarterly assessments were done for each individual in a timely manner. The quarterly nursing assessments gave extensive information about injuries, illnesses, lab work, and general health status on every individual in the sample. Status of timeliness of annual and quarterly assessments was documented on the Master Tracker.	

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	served.	Reporting protocols were present and functional for the individuals in the sample reviewed. Nursing documentation was, for the most, part legible. Issues had to do with the documentation of nursing actions and plans as part of the DAP documentation. These were inconsistently implemented and done in a way that suggested that nursing staff did not understand either its form or function. DAP is a form of SOAP charting which was designed to focus the information documented. • S = Subjective (e.g., John reported that his tummy hurts) • O = Objective (e.g., John refused his meal and was lying in his bed, clutching his abdomen and moaning) • A = Assessment (e.g., John had hyperactive bowel sounds in the right upper quadrant; vital signs: T: 99.2; BP: 156/95; R: 26; P: 144; lungs were clear) • P = Plan (e.g., Notified physician and called for transport to ER. DCP instructed to stay with him until ambulance arrived) DAP combines Subjective and Objective into one category called Data: • D = Data (e.g., John reported his tummy hurts. He refused breakfast and lunch and was lying in his bed clutching his abdomen and moaning) • A = Assessment (e.g., John had hyperactive bowel sounds in the right upper quadrant; vital signs: T: 99.2; BP: 156/95 R: 26; and P:144) • P = Plan (e.g., Notified physician at 2105 and will call for transport to ER. DCP instructed to stay with him until ambulance arrived and notify nurse of any change in his status) Some entries in the records reviewed used the DAP charting format appropriately. Therefore, the data, the assessment, and the plan were clear. Others, however, missed the purpose of DAP, as follows: • Individual #540: an entry on 2/1/10 at 0430 indicated: o D: Diagnose GJT feedings x 24 hours, chronic G stoma irritation and leaking. Slept most of shift. Alert and responsive when awake. Lungs clear. Breathing regular/unlabored. Tolerated feeding well. Head of bed up. Stoma care done x 2. o A: 24 hour chart check done. Assessments completed. o P: Monitor. Follow plan. Most of this information was more appropriate for flow sheets. The assessment should be a description of an assessment related to an issue and the plan should indicate what it is that should be monitored. This DAP example was more extraneous charting that obscured important information and should not be in	

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		this format. • Individual #223: an entry on 2/5/10 indicated: o D: Moaning, may be in pain. o A: Gave Tylenol for pain. o P: Inform oncoming nurse so she can monitor. The A section is for assessment. That was not done in this case. • Individual #165: an entry on 3/16/10 indicated: o D: Up in room. Awake/alert. Respirations easy/unlabored. Abdomen continues to be firm/distended. States "my stomach hurts." No vomiting at this time. o A: Zofran 4 mg given sublingual for anti-emetic measures. o P: follow-up in 1 hour for possible adverse reactions. Again, A should be a description of the assessment. That did not occur. Further, in this example, the medication given could have made the individual's distension worse in the absence of an abdominal assessment. Documentation to resolution was difficult to evaluate in this sample. The reason that documentation to resolution was difficult to evaluate was that many of the acute events in the sample reviewed occurred prior to the date of the documents requested for this review (i.e., three months prior). Then, there were no examples of how the acute issue was resolved. As noted, that was also a problem with the DAP charting issue. For instance, the nurse would often write, "will continue to monitor" for the P (Plan) part of the documentation. Then, there was nothing further noted in the individual's record. Braden Scale assessments were present in all records reviewed.	
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.	There was a process of risk assessment, but it was deeply flawed and dysfunctional as indicated in many sections of this report. The Health Status Team met every six months for all individuals at the facility. The members completed health status risk assessments in designated risk categories. The team was composed of the Primary Care Provider (physician or nurse practitioner), psychologist, residential services representative, risk manager, health status coordinator, Nurse (RN), psychiatrist, dentist, habilitation therapist, dietician, QMRP, and pharmacist. Risk areas and the number of items on that risk's checklist form for each of 17 areas are listed below: • Aspiration/choking (20 items) • Weight (10 items) • Cardiac (4 items) • Constipation (5 items)	

#	Provision	Assessment of Status	Compliance
		• Dehydration (7 items) • Diabetes (2 items) • GI concerns (2 items) • Hypothermia (1 item) • Medical concerns (9 items) • Osteoporosis (2 items) • Respiratory concerns (4 items) • Seizures (12 items) • Skin integrity (5) • Urinary Tract infections (8 items) • Polypharmacy (2 items) • Challenging behaviors (13 items) • Injury (6 items) Each of the above areas had a checklist (called an assessment tool) with as many as 20 and as few as one item. The rating tool contributed to a discussion led by the physician as to the assignment of a level of High, Medium, or Low risk in each of the above areas. Very few individual made it to the high risk level. Some staff reported that the reason for this was that it then required the entire team to meet on that individual at least once per month. The monitoring team has raised this issue to DADS and expects to engage in further discussion of the risk policies, procedures, and practices over the next few months. The problems with the risk level assignment process at LSSLC were: • It was a binary (yes/no) tool that did not discriminate objective intensity of the occurrences and characteristics listed, • Only four of 17 areas had 10 or more items to use as markers of risk • Some items were overlapping, • This process was operating simultaneously with the facility's physical/nutritional management process, however, there was no interaction between the two groups, • The process was also redundant in that nursing staff also monitored weight, • There was no evidence that this process had been tested for reliability • Data for ER visits and hospitalizations were often inconsistent with the assignment of health risk assignments for persons, • The process was enormously time consuming for large numbers of staff, and • The results were not valid, as indicated by the example of 40 hospital and/or emergency room visits for respiratory issues, 28 of which were related to pneumonia, while only 11 individuals were identified at high risk.	

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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.	LSSLC medication administration and dispensing practices were highly flawed, primarily due to the instability and antiquated practices in the pharmacy. The current pharmacy director and the Pharm.D. had been in their jobs for only a few months and were struggling with the limited space available, lack of modern technology, and the implementation of a very flawed distribution system. Nursing had tried to compensate for some of these issues, but with limited success. There have been serious and potentially fatal drug errors made, both from the pharmacy as well as at the administration end of the system. The following comments indicate the flawed nature of the medication administration system at LSSLC and the vast amounts of effort and time that went into maintaining this problematic system. • Medications were distributed to the residences (nearly 3 million individual doses per year or 54,000 doses a week) using Zip Lock bags and Tackle boxes. Each individual had a plastic bag that contained seven days worth of medications in unit dose packages, but for almost every person, the number of pills varied from week to week, and nurses had to check each individual order against the weeks supply and handwrite any variance onto the physician's order on the MAR. • In auditing the MARs for the sample reviewed, the likelihood of a variance in the number of pills to complete a dose was likely to change for at least one or two medications per person at least 30 to 40% of the time. • In nursing practice, whenever the number of pills or capsules required to administer a dose is more than two pills, the likelihood of medication errors increases substantially. The fact is that the number of pills needed to administer a dose at LSSLC not only frequently exceeded this total, but it was likely to change from week to week. • Orders for weekly weights, blood pressures, pulses, and any other data needed related to physicians orders had to be hand-printed on the MARs. Individuals who received sliding scale insulin based on blood sugars also had to have these individual orders hand printed on the orders. This can contribute to errors and is an antiquated way of conducting this procedure.	

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		• More than 7,600 doses of medication per day were counted for two shifts by two nurses, and a third shift count occurred on four residences in Long Pine and in the Infirmary. Narcotic counts, which were done each shift by the outgoing and oncoming shift nurse, required 10 minutes per nurse. To count the cart to prepare for an administration, it took an hour to prepare (e.g., counting the number of drugs in each bin) before the nurse could administer the first medication. During the bin exchange, which was a separate weekly activity, nurses had to hand write instructions for number of pills per person, and the vital signs (e.g., "take pulse before administering, if below 60, do not administer") on each individual MAR. There were 21 medication carts in operation at LSSLC at any given time. • In a sample of 66 sets of Medication Administrative Records, there were 474 medication orders, and out of this there were 115 substitutions requiring handwritten instructions (24%). Of the 66 individuals represented, only 12 did not required a handwritten description of how many drugs were required to constitute a dose. • Nurses tried to work with the previous pharmacist to generate the orders along with any parallel instructions electronically so that this amount of hand-work was not required. This was not successful, in spite of the fact that the program was capable of doing the task. • One dose could be anywhere between one and 14 pills per dose. For instance, Dilantin was only stocked in 100 mg pills. If the person had an order for 400 mg, four pills would be required for a single dose. The number of pills per dosage had to be handwritten on the MAR each week by the nurse, because the number of pills per dose could also vary from week to week. A modern system of medication administration, such as Pyxis, would eliminate individuals getting inaccurate doses of medication, which was happening at too high a frequency during the onsite monitoring tour. According to the staff interviewed, pharmacy had the capacity to include instructions to replace the ones written by hand on the MAR by the nurses each week. This type of system would also eliminate the wrong medications being dispensed. In some cases, doses of 50 mg were mixed in with 25 mg pills. This was not working and nurses were being set up to fail because the system was flawed. Nurses shouldn't have to count every pill in every drawer once every shift.	

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		The current system resulted in some of the following outcomes: • Nurses were spending hours per shift doing tasks that should be done electronically. • Nurses were taking short cuts (e.g., setting up for the 4:00 pm and 8:00 pm medication passes in advance, which was strictly not in compliance with facility policy. • Serious and frequent errors were occurring that would simply not be an issue if a modern system of dispensing both medications and comprehensive Medication and Treatment records was available to the facility. • At least part of the turnover in nursing in this facility could probably be attributed to this issue.	

Recommendations:

1. There needs to be a modern system of drug distribution, and the pharmacy should, as soon as possible, develop a new system. The facility should consider an electronic MAR and TAR with all individualized instructions printed on the document. This should be within the capabilities of the current system.

2. Ensure Health Management Plans address all of the variables that might be impacting the individual's chronic condition.

3. Improve treatment of GERD, incontinence, and respiratory services as per the health care guidelines. Additional training on the HCGs, and incorporation of the HCGs into daily nursing practice are recommended.

4. Ensure head to toe assessments are completed when individuals are assessed for acute illness.

5. Documentation, particularly the DAP charting as specified in the Health Care Guidelines, needs to be trained and monitored until nurses are implementing this process more systematically. They did not have an adequate feedback system, and were not documenting the assessment portion of the system correctly. Instead, they were most often writing actions. Further, the single most common entry under the plan section was that the they will continue to monitor, however, there was no specification regarding what would be monitored, when that might happen, how they would complete that action, or the plan to notify the primary care practitioner. The facility should consider developing a process for unit nurses to review individual records for DAP charting and provide feedback to one another on the quality of that documentation.

6. Documentation to resolution was difficult to track in the record, and might be reviewed and monitored across unit nurses as described in recommendation #1 above.

7. There was little documentation of communication with interdisciplinary team members. There should be a mechanism to train nurses as to when such documentation is appropriate.

8. There was a lot of redundancy in documentation. Future efforts might focus on the reduction of such redundancy, such as figuring out when something is documented more than once, if there is a good reason for such, and if not, stop.

9. Much of the time when the DAP charting was not functional. The facility should obtain assistance from persons with expertise in the SOAP format and develop an audit tool to that end.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance**: Documents Reviewed: o All documents noted in sections J and L above o Drug Utilization Evaluations o Adverse Drug Reaction reports o Pharmacy and Therapeutics committee meeting minutes Interviews and Meetings Held: o David Leeves, Director of Pharmacy o Abimbola Farinde, Pharm.D. Observations Conducted: o Psychiatry clinics and Pharm.D. participation o Pharmacy and medication distribution system
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The pharmacy director and the Pharm.D. were both employees of less than two months duration at the time of the baseline onsite review. Many questions posed by the monitoring team to the pharmacy director could not be answered because he had not acquired enough information since he started at LSSLC. The primary method of distribution of pharmaceuticals to each residence included a system using Zip lock bags and tackle boxes. Each individual had a zip lock bag that contained the weekly medications in unit dose packages. The administration of approximately 2.8 million doses of medication per year happened utilizing this system at LSSLC. The term "system," however, is used loosely here because this was not a desirable, typical, or necessarily safe way to manage medications. There was no formal lab matrix in use at LSSLC. In developing such a tool, prolactin needs to be added for monitoring with the use of Paroxetine and Risperidone. The Pharm.D. was able to produce one adverse drug reaction report over the past year. This was undoubtedly a low number given the number of medications that were administered each year At LSSLC.

	One chemical restraint log for the quarter 6/1/09 through 8/31/09 was produced with "none administered." There were no other logs for the remainder of 2009 or the first quarter of 2010. There was only one P&T committee meeting held in 2009 and none to date in 2010. DUE reports were only quantitative, totaling the number of individuals taking either anticholinergics or benzodiazepines. There was not a qualitative look at the appropriateness per individual of the use of such agents by diagnosis at LSSLC as per the Settlement Agreement guidelines. The pharmacy itself was quite small for the amount of medication that it dispensed per year. There was an alert on the wall of an office to watch certain units within the facility for shortages of medication. These shortages were not reported until the middle of the week by the unit to the pharmacy, thereby making it difficult to trace the cause of the shortage. The technicians were monitoring these units for this occurrence. Individual #217 received Abilify 5 mg. in addition to Haldol 5mg. from 2/25/10 to 4/13/2010 despite the order for discontinuation on 2/25/10.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug	At the time of the onsite baseline review, this process was not occurring, per the record review, observations, or interviews conducted by the monitoring team.	

#	Provision	Assessment of Status	Compliance
	literature.		
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.	This process was in development with inconsistent quarterly reviews noted throughout the baseline records review. The following records had only one polypharmacy review between 9/09 and 4/10: • Individual #31, Individual #488, Individual #9, Individual #569, and Individual #90. Also, the quality of the review was in question because many of the reviews had inadequate information: • A request that a lab be drawn that had already been drawn for Individual #180. • The 12/21/09 review of Individual #321 noted that no MOSES has been done, even though there was one in the record from 4/6/09. • Individual #203 was flagged in the 11/30/09 review as not having a DISCUS since 11/08, however, there was one in the record from 11/7/09. This particular individual's review appeared to be a templated copy of the previous quarterly review and made it appear that the record was not reviewed when the quarterly review was done. • The quarterly review of Individual #31 asked for potassium levels to be drawn on this individual, however, there was no follow-up review. It is noteworthy that the Pharm.D. was told, when she requested a record on the unit for review, that she could not have it for various reasons. She noted that this made these sorts of reviews difficult. Facility management should look into this.	
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	A "Stat" medication log was produced by the Pharm.D. for review, however, it did not meet the requirements detailed in this provision item.	

#	Provision	Assessment of Status	Compliance
	monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.		
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.	This actions required by this provision did not appear to be occurring based upon the review of the monitoring team. Of concern to the monitoring team was the lack of apparent input from psychiatry and the primary care providers to the review. There were frequent missing signatures by the psychiatry providers and there were no responses to questions posed. A few examples cited from the record review are below. • No annual labs were drawn on Individual #54 despite reminders on the polypharmacy reviews to the physicians (including psychiatry) that she was overdue. Psychiatry did not appear to monitor lipids or CMP despite the individual taking Zyprexa. • The pharmacist noted the increased risk of bleeding to Individual #106 after being placed on Coumadin with Prozac, yet psychiatry made no comment on whether or not the individual could be changed from Prozac to a less problematic medication. • In the case of Individual #367, there was a request in both the 9/12/09 and 4/15/10 polypharmacy reviews for the attending psychiatric provider to evaluate polypharmacy, but there was no comment by the attending. Neither review had a psychiatry provider's signature.	
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 was noted on the quarterly review. This Pharm.D. had only been at the facility for four weeks at the time of the baseline onsite review. The records of Individual #106, Individual #180, Individual #9, Individual #321, and Individual #488 were missing either DISCUS or MOSES, or both, on a quarterly basis. Only Individual #321 has a notation in the quarterly review that these were delinquent.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	This was not occurring at the time of the onsite baseline visit.	

#	Provision	Assessment of Status	Compliance
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.	This provision was in development at the facility. The Pharm.D. was able to produce a quantitative DUE for anticholinergics and benzodiazepines. Future work needs to be done with regard to qualitative DUEs looking in more detail for which conditions benzodiazepines are prescribed, not simply a counting of numbers of individuals receiving the drug.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	No evidence was provided to indicate that this was occurring at LSSLC.	

Recommendations:

1. New computer systems and a Pyxis system are needed to decrease the error rate and improve efficiency in a facility that was distributing 2.8 million doses of medication per year. The pharmacist commented that the existing computers were old and slow. Reduction of errors of both omission and commission require a more up to date method of distribution than the one in existence.

2. A larger physical facility or, at least, additional storage capability is needed for the pharmacy. The physical facility was very small and the system of tackle boxes and zip lock bags for transportation of medication to from the units was problematic from an accuracy perspective, both at the delivery and recipient ends of the system.

3. LSSLC needs to institute a DUE and ADR system that provides meaningful and useful data to all stakeholders. It was very hard to believe that only one ADR existed over the past year in a facility administering nearly 2.8 million doses of medication per year. For example, there were at least two individuals who became toxic (requiring hospitalization) on their medication from the review of the records: Individual #90 (lithium) and Individual #423 (phenytoin).

4. A formal lab matrix needs to be developed for appropriate monitoring of medications at certain intervals. It would be helpful to develop this in

the P&T committee meetings and then post to each record for easy review by each provider.

5. P&T committee meetings need to include psychiatry and should occur no less than quarterly, and perhaps more frequently, in the beginning in order to develop standards as suggested in provision N4 above.

6. Drug Utilization Evaluation and Adverse Drug Reaction reports were in need of collection and preparation. It is hoped that with the addition of a Pharm.D. and pharmacy director, the facility will meet the requirements of this section of the Settlement Agreement.

7. Pharmacy staff should have access to all records that are relevant to their work.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o Current Census Alpha o CVs for PNMT members o LSSLC Habilitation Therapy Services policy, dated 02/22/10 o DADS policy, Occupational/Physical Therapy Services #014P, 11/04/09 o OT/PT Evaluation template o POI Section P: PNM QE Checklists completed by T. Anastasi o Verification of Continuing Education for SLPs, OTs, and PTs o Habilitation Registered Therapists list o NMT meeting minutes o OT/PT Evaluations for the following: • Individual #129, Individual #211, Individual #236, Individual #68, Individual #108, Individual #580, Individual #96, Individual #128 Individual #136, Individual #393, Individual #551, Individual #104, Individual #202, Individual #154, and Individual #467, Individual #402, Individual #469, Individual #44, Individual #164, Individual #225, Individual #142, Individual #258, Individual #513, Individual #560, Individual #592, Individual #497, Individual #198, Individual #127, Individual #570, Individual #62, Individual #567, Individual #323, Individual #22, and Individual #565 o OT/PT Activity Plans and Staffing Summaries o PSPs for the following: • Individual #565, Individual #129, Individual #323, Individual #587, Individual #567, Individual #393, Individual #62, Individual #592, Individual #572, Individual #198, Individual #398, Individual #599, Individual #497, Individual #42, and Individual #422 o PNMP format o Dining Plan format o PNMP Monitoring Sheets completed for December 2009 and January/February 2010 o PNMPs submitted for LSSLC individuals o Staff New Employee training curriculum o Meal Observation Sheets o Dining Plans and related training sign-in sheets o Mealtime Observation Sheets completed by Danethia Criswell on 04/19/10 o PNMP Coordinator Training Handouts o List of choking events o List of individuals with pneumonia diagnosis o Hospital Admission list

	o ER Visits 2009-2010 o HST Meeting minutes and attendance rosters o PNMP lists o HST High Risk Individuals 2010 o 2009 Wound Clinic Spreadsheet o High Risk List 03/16/10 o Medium Risk List 03/15/10 o Low Risk List 03/16/10 o Individuals using Lemon Ice o Individuals using Thicken Up o Modified Barium Swallow Studies 02/09 to 03/10 o Diet Order list o Health Status list 03/16/10 o Injuries Sustained by Falls Reporting Period 11/01/09 2/08/10 o Choking incident documentation for: • Individual #332, Individual #142, Individual #457, Individual #368, Individual #507, Individual #339, Individual #145, Individual #23, and Individual #565, o Individual Record documents including: • Personal Support Plans and addendums • Medical Evaluations for last two years • Nursing Annual and Quarterly Assessments for the last year • X-ray reports for last two years, Nutrition Notes for last 12 months • Communication Assessments/Updates and OT/PT Assessments/Updates for last two years • Functional Eating Survey for last two years • Action Referral notices • Health Risk Assessment Tool • QMRP Professional notes for previous 12 months of PSP • Skill Acquisition Plans for Habilitation Therapies • Incident reports related to falls, transfers, choking, mealtime in the last 12 months • NMT documentation • Wheelchair related assessments • Hospitalizations discharge summaries for last 12 months • ER discharge summaries for last 12 months • Infirmary discharge summaries for last 12 months • Integrated Progress Notes for last quarter • GI consults for last 12 months • PNMP and Dining Plans o For the following individuals: • Individual #560, Individual #554, Individual #561, Individual #549, Individual #513, Individual #44, Individual #353, Individual #225, Individual #466, Individual #570,

	Individual #22, Individual #202, Individual #174, Individual #321, Individual #1, Individual #565, Individual #334, Individual #10, Individual #458, Individual #535, Individual #332, Individual #137, Individual #521, and Individual #223 Interviews and Meetings Held: o Christina Pedroni, MS, CCC-SLP, Habilitation Therapies Director o Nancy Jo Flournoy, MS, CCC-SLP o Christi Hodges, MS, CCC/SLP o Rhonda Hampton, MS, CCC/SLP o Jeremy McKnight, OTR o Cassi Hairgrove, OTR o Sharon Setzer, OTR o Jennifer Burson ,COTA o Jason Burson, COTA o Brenda Webb, COTA o Gail Harris, PT o Tabitha Anastasi, QE Monitor assigned to Settlement Agreement sections O, P, and R o Linda Murley, PNMP Coordinator Supervisor o Barbara Draper, Active Treatment Director o PNMP Coordinators o Meeting with PNMP Coordinators and Active Treatment Director o Discussions with various supervisors and direct care staff o Discussions with various day program staff Observations Conducted: o NMT Meeting 04/21/10 o PNMP Clinic 04/20/10 o Mealtimes o Living areas and day program areas
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: LSSLC had a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. The NMT documented consistent participation by SLPs, RDs, QMRPs, and nurses, but less than acceptable attendance by other core team members, such as OTs, MDs, and PTs. The current systems intended to assign and manage risk issues were not coordinated and integrated; instead they functioned in a parallel manner. Assignment of risk did not consider thresholds and outcomes

	related to recommendations and interventions. A number of individuals were listed at medium or low risk for aspiration, choking, osteoporosis, and skin breakdown when, in fact, they had actual diagnoses in these areas. Use of the NMC Screening Tool was not evident in documentation submitted but was used by report to guide frequency of review. A number of issues were observed by the monitoring team to indicate that PNMPs were not consistently and properly implemented. Staff training was not competency-based and monitoring did not occur with sufficient frequency to ensure that staff compliance was routine. The existing monitoring methods were evolving at the time of this review, but plans were not in place to use risk levels to drive the intensity and frequency of PNMP monitoring. There was also no plan in place to track and trend findings to permit targeted and timely staff training. The existing PNM coordinators did not demonstrate sufficient competency to ensure that individuals were closely monitored and that there was sufficient compliance with implementation of critical PNM supports as outlined in the PNMPs and dining plans. As described throughout this review, there were numerous examples of inadequate implementation of these plans by staff. In one case, an individual had not received the correct diet texture for at least nine months, unnoticed by staff at any level until she experienced a choking event that placed her at risk of death. The current system of monitoring was ineffective in the identification and remediation of these errors and this placed all individuals at risk of harm for aspiration and/or choking, and increased the potential for tube placement. The dining rooms in some homes were large and the atmosphere was chaotic, not at all conducive to a safe and pleasant mealtime environment aside from the fact that it complicated adequate supervision and supports for staff and for the individuals for whom they were responsible. New employees were observed providing assistance and supervision to individuals at mealtimes with no supervision, coaching, or monitoring by supervisors. One supervisor was observed providing coaching, modeling and training to a new employee inconsistent with the individual's Dining Plan. Staff did not demonstrate an understanding of the need to provide supervision, oversight, and prompts as prescribed in the Dining Plan. This was exemplified by the home manager who stated that there was "only one feeder" at a table and so only needed to assign one staff to that table. Besides the person who required staff assistance to eat, there were three others needing supervision, some physical assistance, and verbal and physical prompts.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional	PNM team consists of qualified SLP, OT, PT, RD and as needed, consultation with MD, PA, RNP. The current state-approved policy, dated 12/09/09, stated "the NMT is typically comprised of the: a. Physician; b. Occupational Therapist (OT); c. Speech Language Pathologist (SLP); d. Registered Nurse (RN); e. Dietician; and f. Other disciplines as indicated by need including but not limited to Physical Therapy, Certified Occupational Therapy Assistant, Licensed Vocational Nurse (LVN), psychologist, QMRP, home staff, and others."	

#	Provision	Assessment of Status	Compliance
	Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, 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.	The purpose of the Nutritional Management Team was to: 1. Identify individuals at risk for dysphagia/aspiration, 2. Ensure individuals received adequate nutritional intake, 3. Decrease instances of choking/aspiration, 4. Decrease health problems secondary to aspiration, 5. Identify individuals with gastroesophageal reflux and other gastrointestinal (GI) conditions, 6. Make evaluation and treatment recommendations, 7. Provide training to staff in Nutritional Management issues, and 8. Conduct other activities as appropriate to ensure safe eating and adequate physical and nutritional health. A team that addressed PNM concerns was in place at LSSLC. A meeting was conducted the week of the on-site baseline review on 04/21/10. Membership included SLP, OT, RN, dietitian, QMRP, and home manager. Other members included social worker and psychology as needed. The physicians were invited and some attended when an individual on their caseload was reviewed. This group at LSSLC was referred to as the Nutritional Management Team (NMT). NMT meeting minutes were submitted for meetings held from March 2009 through February 2010. Twenty-one meetings were held across each month during the past year with the exception of November 2009. Attendees included the following per the sign-in sheets submitted: • SLPs: 20/20 meetings • OTs/COTAs: 3/20 meetings • RDs: 19/20 meetings • RNs/LVNs: 20/20 meetings • QMRPs: 20/20 meetings • DCPs: 14/20 meetings • Psychology: 16/20 meetings • Home Managers: 2/20 meetings • Physicians: 5/20 meetings • Social Workers: 2/20 meetings Attendance was consistent by SLPs, nursing, and QMRPs with representation at each of the 20 meetings. Dietitians attended 95% of the meetings, psychology attended 80% of the meetings, DCPs attended 70%, and social workers and home managers attended 10% of the meetings. Physicians attended only 25% of the meetings, including those held in March, July (two), August, and September 2009 (only one). An OTR attended one meeting and a COTA attended two other meetings during the last year. There was no evidence that PT participated in the NMT meetings at all. There is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management need. Resumes/CVs for team	

#	Provision	Assessment of Status	Compliance
		members were submitted as requested, including numerous QMRPs; RDs (Angela Wade, Leighann Johns, and Catherine Ratcliffe); SLPS (Nancy Jo Flournoy, Christi Hodges, and Rhonda Hampton); the Habilitation Therapies Director, Christina Pedroni; OTRs (Jeremy McKnight, and Cassi Hairgrove); and COTAs (Jennifer Burson, Jason Burson, and Brenda Webb). Though the resume for Gail Harris, PT and Sharon Setzer, OTR were also submitted, they had not attended any meetings of the NMT in the past year. Cheri McGuire, RD had attended most of the meetings, but no resume was submitted for her. There was no evidence that a dietitian had attended the meeting on 12/01/09, though Ms. McGuire attended on the meeting held 12/09/09. Beginning in January 2010, Leighann Johns attended the meeting held that month and the two in February 2010. Brenda Webb was the only COTA who had attended NMT meetings on two occasions and the OTR who attended was no longer employed at LSSLC at the time of this review. All three SLPs generally attended each meeting with four to nine years of experience each. Resumes for other NMT members were not submitted. State policy identified that "each regular member of the NMT should complete ongoing training in the area of physical and nutritional management for persons with developmental disabilities." There was no indication that LSSLC had a plan for this training, though evidence of inservice and limited continuing education opportunities were noted for some of the NMT members. <u>PNM team meets regularly to address change in status, assessments, clinical data and monitoring results</u>. Per state policy, meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to address follow up activities, and at any phase in the Nutritional Management process. Meeting minutes were submitted with evidence that the NMT met 20 times from March 2009 through February 2010. The NMT met at least two times per month from July 2009 through February 2010 with the exception of November 2009. The NMT met three times during the month of December (12/01, 12/08, and 12/15) per the meeting minutes submitted. By report, meetings were chaired by one of the three SLPs in rotation, with at least one or two of the three clinicians attending all of the meetings, and all three attending five meetings. In addition, the Habilitation Therapies Director attended approximately 50% of the meetings as well. Meeting minutes were comprised of a variety of chart review findings including diet order, diagnoses, weight history, physician orders, consults, and other assessments available to the NMT during the meeting. The meeting chairperson summarized the discussion with recommendations for actions and interval for the next review as	

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		indicated. Chart reviews were conducted by the SLPs prior to the meeting. The most current meeting minutes consistently identified the reason for review, such as • review following MBS (Individual #24) • follow-up from a previous meeting (Individual #56) • post-choking event (Individual #332) • occurrence of aspiration pneumonia (Individual #203) Meetings ranged in length from 30 minutes to more than three hours. The average number of individuals reviewed during these meetings was 12, ranging from one to 22 individuals. Approximately 72 individuals were reviewed during the period for which meeting minutes were submitted. There were 32 individuals reviewed three or more times during that time. They included the following: • Individual #444 (10), Individual #385 (9), Individual #389 (8), Individual #11 (7), Individual #44 (6), Individual #214 (6), Individual #502 (6), Individual #16 (6), Individual #174 (5), Individual #36 (5), Individual #488 (5), Individual #447 (5), Individual #285 (5), Individual #137 (5), and Individual #127 (5). Nine others were seen on four occasions, and eight were seen three times. Reason for review and NMT risk level were clearly stated for each individual and the date of the last review was generally identified. It was not, however, always clear that the individual had been seen multiple times previously. The summary provided limited analysis or synopsis of group discussion and often recommendations included the interval of next review only, rather than actions to be taken to address the issues for which the individual was being reviewed. Below is one example: • Individual #385 was reviewed on 03/24/09 to monitor acceptance of oral intake post G-tube placement. There was no evidence of review during the meeting held on 04/21/09, though the minutes on 05/27/09 indicated that he had been reviewed in April. Chart review findings presented for the May meeting indicated a seven pound weight loss in a week and recurrent vomiting and diarrhea from 04/20 through 05/24. Notations were only that he had persistent vomiting and diarrhea (more than 20 episodes), gagging and refusing Ensure and food, and that his weight loss was "expected from illness." In addition, there were a couple of references to the gagging and vomiting as a behavioral issue. It was recommended at that time that he be reviewed in one month. Documentation included for the meeting on 06/24/09 did not update information regarding his health status past that provided for the meeting in May. There was no summary of discussion or recommendations made by the NMT. Minutes in July indicated that he had not been reviewed in June due to hospitalization. Documentation indicated that Individual #385 continued to lose weight, an additional 7.4 pounds	

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		in two months. Unplanned weight loss since 04/11/09 was approximately 13% and vomiting persisted after oral intake through 07/27/09. There was further reference to vomiting being behavior-based. While recommendations at that time were to continue NPO status for another month, there was no recommendation for subsequent follow-up. It was noted, however, that he was reviewed on 08/25/09, at which time his weight was 95.2, that is, another .4 pounds lost. The vomiting and diarrhea had continued though he had remained NPO and received only enteral nutrition via pump. He was to be reviewed in three months despite apparent ongoing PNM health concerns that were unresolved at least five months later. The findings of PNMP monitoring were unknown to the NMT and as a result they were not used in the review of individuals with PNM risks. <u>PNM plans are incorporated into individuals' Personal Support Plans (PSPs)</u>. PNMPs were only marginally addressed in the PSPs reviewed. The PSPs reviewed reflected integration of the PNMP in the following ways: • PNM-related information was included in the Assessment section of the PSP under a variety of headings including Physical Medical, Nursing, Pharmacy, NMT, Nutrition, OT/Nutritional Management, Dining Plan, OT/PT, and Speech, though each of the headings were not included in each PSP. • PNM-related assessments such as the OT/PT Evaluation Update were included in their entirety under the Health Services section of the PSP. • The Assessment/Services section of the PSP again listed the recommendations previously identified in the assessments. • The General Discussion section of the PSP occasionally included a heading for the PNMP and stated that the PNMP was reviewed, was accurate, and did not have any changes that needed to be made or other similar statement to that effect as in the case of Individual #129. However, as in the case of Individual #96, there was no evidence that the PNMP had been reviewed by the PST. While there was some limited evidence of PST review and discussion of the PNMPs, they continued to appear as a habilitation therapies responsibility rather than that of the entire team. <u>Identification, assessment, interventions, monitoring, and training as outlined in sections O-2 through O-8 as described below.</u> See below.	
O2	Commencing within six months of	<u>A process is in place that identifies individuals with PNM concerns</u>. Per the current LSSLC	

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	the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	policy implemented on 01/31/10, a Nutritional Management Screening Tool was utilized in the "discovery or referral phase" of the process to identify each individual's Nutritional Management Risk. Risk indicators were identified across three levels of risk: High (Level 1), Medium (Level 2), and Low (Level 3). There was no evidence that this or other screening tool was used by the NMT at LSSLC to drive review based on level of risk in the documentation submitted. It was stated in the interview, however, regarding the NMT, that the state screening tool had been in use since March 2009. Individuals at high risk had experienced a recent aspiration, aspiration pneumonia, or unexplained weight loss. Those at medium risk were reviewed in two to three months. Those at lowest risk were dismissed if health and intake were adequate. There was no mention of these risk levels in the documentation submitted. In addition, the HST screening tool was not referenced in the documentation by the NMT. Individuals reviewed by the NMT were identified by referral, such as post-gastrostomy tube placement or weight loss, for example, or via recommendations for follow-up from a previous review. There did not appear to be a mechanism to identify individuals at highest risk for PNM-related concerns in order to provide routine proactive review and plan development to address those issues. There was also a disconnect between the NMT and the system of assigning risk via the Health Risk Screening completed on individuals living at LSSLC, though the Habilitation Therapies clinicians completed that HST screening for aspiration pneumonia and choking. As a result, some individuals were not reviewed with sufficient frequency. Often, only a negative health outcome triggered review. For example there were 31 individuals included on the list, "HST High Risk Individuals 2010" submitted to the monitoring team. Only half of these individuals were reviewed by the NMT. For example: • Individual #573, Individual #419, and Individual #437 were reviewed on only two occasions in the last year despite being identified at high risk for aspiration by the HST. Individual #437 was also considered to be at high risk for choking. • Individual #42, Individual #140, and Individual #172 were considered to be at high risk for aspiration, but were not reviewed at all in the last 12 months by the NMT. • Individual #142 experienced a choking incident on 01/15/10, yet there was no subsequent review by the NMT and he was listed as low risk for choking per the HST. • Individual #457 experienced two choking incidents within a week on 09/14/09 and 09/19/09, yet there was no subsequent review by the NMT and, moreover, he was considered to be at low risk for choking according to the HST screening. • Individual #23 experienced a choking event on 08/15/09. An assessment was conducted by the SLP two days later and there was no review by the NMT; she was listed as moderate risk for choking per the HST.	

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		• Individual #565 (02/03/10), Individual #145 (03/31/09 and 04/15/09), Individual #368 (11/16/09), and Individual #339 (third choking event in a year with aspiration pneumonia related to event on 05/15/09) experienced choking incidents with no evidence of review by the NMT. Each of these four individuals was listed at low risk for choking per the HST. • Another 12 individuals were identified at moderate risk for choking, but also were not reviewed by the NMT. Observations conducted by the monitoring team found that implementation of dining plans across a number of homes was insufficient to ensure safety for all those with choking and/or aspiration concerns, particularly with regard to position, alignment, and support, as well as food texture, liquids consistency, adaptive equipment, and assistance strategies. It was of concern that these issues had not been identified and addressed appropriately. The monitoring team also observed numerous instances of inadequate alignment and support during meals and other times during the day. Inadequate trunk alignment and support, foot support, and/or head alignment were noted for each of these individuals. Some examples were: • Individual #369, Individual #22, Individual #361, Individual #467, Individual #597, Individual #521, Individual #96, Individual #560, Individual #430, Individual #450, Individual #406, Individual #353, Individual #515, Individual 388, Individual #454, Individual #549, Individual #10, and Individual #225. The monitoring team observed numerous instances of incorrect food texture or liquid consistency offered to individual and/or other concerns inconsistent with the dining plan. The Habilitation Director accompanied the monitoring team to the homes observed during mealtimes. It was of great concern that there were so many errors during mealtime placing these individuals at risk of harm from aspiration or choking. This information was presented to LSSLC management during the onsite tour so that immediate action could be taken. Some of these examples included: • Individual #597 was presented medication via a tongue blade and liquids were poured into her mouth from a paper cup. • One nurse assisted another during a medication pass by lifting Individual #521's head into hyperextension. • Individual #1 was eating chips from a spoon. The bite size per his dining plan	

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		was no larger than a quarter and many bites taken exceeded this size. • Individual #334 was to receive two or three bites of lemon ice before the meal and after every third bite of food or liquid. The staff assisting him was observed to present only one bite of lemon ice with a fork. The staff person also presented heaping spoonful of mashed potatoes to Individual #334, though his Dining Plan indicated that bites should be no larger than a teaspoon. He coughed several times throughout the meal. • Individual #108 did not have a dycem mat available for use during the meal observed by the monitoring team. When prompted, the staff person provided it. He was also supposed to receive no more than a quarter of a glass at a time. The staff assisting him filled his glass half full. • Individual #409 was drinking from a full glass, though his dining plan prescribed that it be half full. • Individual #563 was observed during a meal. There was one staff person sitting with her and a supervisor was standing over her saying, "chew, chew, chew". The Dining Plan indicated that she should be prompted to put her spoon down between bites. Individual #563 was eating pudding. The individuals at that table did not receive a beverage and another individual did not get a knife (Individual #250). • Individual #430 was observed taking large bites, though he was to be limited to teaspoon size bites of nickel size pieces of food. The food pieces were all larger than a nickel. • Individual #458 was observed coughing and trying to clear after her meal, but no one attended to her until the staff noticed the monitoring team watching her closely. • Individual #156 was to have food mixed with pureed fruit per her Dining Plan, but this was not done. • Individual #365 was eating whole pieces of toast with jelly. Her Dining Plan indicated that she should have staff assistance to cut her food into small pieces to prevent choking. After the monitoring team moved to another table, the direct support staff sitting with her stood to cut her food. • Individual #128 was observed during two meals to be leaning to the left. • Individual #342 was noted to have a significant tremor while eating. He had difficulty scooping and direct support staff began to assist him toward the end of the meal. The plan indicated that his glass was to be filled one quarter to one half full. Direct support staff offered him three full glasses of his beverage. He rapidly drank each one without stopping, with loss of liquid noted. • Per his Dining Plan, Individual #174 was to receive thin milkshake thick liquids presented from a spoon. Liquids presented were pudding thick. His foods were to be thinned to an applesauce consistency, yet he was served thick pureed eggs	

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		and cereal. The direct support staff assisting him was new and the supervising staff admitted that she had not provided coaching, training, or oversight to prevent these errors. • Individual #179 was to receive lemon ice no more than five minutes before her meal and one more medicine cup full halfway through the meal. The direct support staff offered the lemon ice throughout the meal, chopping the ice with a fork, and serving it in the form of ice chips. • Staff assisting Individual #546 were to allow two to three seconds between sips of fluid. He was offered fluids without pause. • Individual #265 was observed to take very large bites without staff intervention. His glass was to be only half full. The glass was full and he drank his beverage quickly with repeated consecutive swallows. • Individual #450 received a whole piece of toast, though his dining Plan indicated that all foods should be cut into quarter-size pieces. • Individual #286 was observed to eat pieces of bread larger than a nickel as prescribed on his Dining Plan. Direct support staff had to be prompted by the monitoring team to correct this. • Individual #561 was observed to have a severe coughing episode and throughout this time, the direct support staff with her continued to attempt to present fluids for her to drink. • During one meal, one direct support staff was seated to provide one to one assistance for one individual. Three other individuals were seated at the same table, and each required some level of prompts or supervision for safety per his Dining Plan. When the supervisor was asked about table assignments, the monitoring team was told that they could only have a few staff in the room at a time due to fire safety regulations. It was also noted that on the other side of the dining room where the female individuals were eating, there was an abundance of female staff, in one case three staff at one table of four individuals and numerous others present in the area and seated at other tables. The Mealtime Observation Sheet completed on this date did not identify any concerns. <u>Process includes level of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk levels</u>. As described above, there was no evidence of the use of the NMT Screening tool, used statewide, in the documentation submitted. Further, the NMT at LSSLC did not practice the guidelines as outlined with regard to required review of all choking incidents at the next NMT meeting. As described above, the risk level designations by the HST were not reflective of actual risk with regard to aspiration and choking, for example. Follow-up by the NMT was inconsistent with state policy and the generally accepted professional standard of care as defined in the Settlement Agreement and Health Care Guidelines.	

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		Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team. All PNM-related assessments were completed per the annual staffing schedule rather than based on increased risk level. Interim assessments were conducted for some individuals based on referral as in the "chairside" assessments generally conducted after a choking incident. There was no evidence, however, that the assessment was comprehensive, that is, that it involved other team members. The Health Status Review Committee met monthly to review all individuals living at LSSLC and assigned the following risk levels in 18 domains: High Risk (Level 1): This rating typically applies to an acute or unstable condition that requires timely collaboration and increased intensity of intervention to achieve an optimal health outcome. A physician can determine that any condition is High Risk at any time without collaboration from the HST. Individuals discharged from the hospital should have their risk level reviewed by the physician. Once a High Risk condition is identified, the PST will meet within 5 working days to formulate a plan. The plan will be implemented within 14 days. The PST will meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition is stabilized and the risk level is reduced. Medium Risk (Level 2): This rating typically applies to ongoing conditions that are stable but require active monitoring to insure optimal health outcomes. This level also applies to conditions that may normally be considered high risk but have appropriate supports in place that have rendered the condition stable over time. Individuals at Medium Risk are reviewed and monitored by appropriate members of the PST at intervals between 30 and 180 days. The PCP or members of the PST will determine how often the PST will meet to monitor the effectiveness of the plan of care. Low Risk (Level 3): This rating typically applies to conditions that are stable and require minimal or no active treatment. Individuals at Low Risk are monitored by appropriate members of the PST at intervals greater than 180 days but at least annually unless there is a change in the health condition and risk rating. In fact, these ratings were grossly inconsistent with actual facts regarding many individuals with PNM risks. For example, there were only three individuals identified at high risk for choking and only 12 were assigned medium risk, yet there had been at least	

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		11 choking incidents since March 2009. For example Individual #457, Individual #145, and Individual #507 had experienced multiple incidents during that time. Individual #339 had experienced three choking events in the last two years. Each of these individuals was rated at low risk. Individual #23, Individual #565, and Individual #332 had choking events in the last year. Approximately 16 individuals were considered at medium risk and only two were considered to be at high risk of choking per the HST (Individual #437 and Individual #16). There was no evidence of a choking event for either of these two individuals in the last year submitted. Approximately 12 individuals were considered to be at high risk of aspiration. Twenty others were listed at medium risk. Only Individual #36 was considered to be at high risk for skin breakdown, yet there were numerous individuals seen in wound clinic with Unstaged, Stage II, and Stage II decubitus ulcers. Individual #173, Individual #187, and Individual #202 were each followed in Wound Clinic for Stage II wounds on their buttocks and/or coccyx, yet were listed at low risk with regard to skin integrity. Individual #560 was seen in Wound Clinic numerous times for Stage II and III decubitus ulcers on her buttocks and coccyx, yet was not included on the HST risk list. All comprehensive assessments are conducted by the PNM Team, identify the causes of such problems, and contain proper analysis of findings and measureable, functional outcomes. Assessments were generally not conducted outside of the annual staffing schedule. Annual assessments included update evaluations. Mealtime assessments were conducted following most choking incidents though were completed by the SLP only. See section P of this report below.	
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	All individuals identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP). There was a plan for each individual living at LSSLC to have a PNMP and a dining plan (initiated 4/1/10). The format was generally consistent. As appropriate, PNMP consists of interventions/recommendations regarding: a. Positioning/alignment; b. Oral intake strategies for mealtime, snacks, medication administration, and oral hygiene; c. Food/Fluid texture; Adaptive equipment; d. Transfers; e. Bathing; f. Personal care; g. In-bed positioning/alignment; h. General positioning (i.e., wheelchair, alternate positioning); i. Communication; and j. Behavioral concerns related to intake. The format for PNMPs included supports and strategies related to assistive equipment, communication, mobility, transfers, movement techniques, positioning (seating, bed), skin care, bathing/toileting, dining equipment, and mealtime instructions. Oral hygiene and medication administration were not addressed. Pictures of adaptive	

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	are likely to provoke swallowing difficulties.	mealtime equipment were to be integrated in the Dining Plan as well as a picture of the individual in his or her mealtime position. An additional picture showed the individual in his or her seating system/wheelchair, as indicated. There was an established plan to ensure that all individuals would have a Dining Plan by 04/01/11. Those currently without them would have one developed at the time of their annual staffing. Each individual had a PNMP. Each plan was dated, but there was no specific implementation or revision date. Changes to the plan were highlighted, including the date of the PNMP. Individuals who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above. All individuals who received enteral nutrition had PNMPs, even if they were NPO, receiving all their hydration and nutrition via enteral tube. PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team. The PNMPs were developed during the PNMP clinic without significant input from team members other than the OT, PT, and SLP. By report, the PST discussed the plan and made recommendations for changes as indicated. It appeared, however, that the recommendations in the clinical assessments by Habilitation Therapies were listed. It was noted in one instance (Individual #332), that the SLP had recommended she continue with a chopped diet based on her oral motor skills and swallowing integrity, however, the PST decided to provide a downgraded ground diet**.** It was not evident that the PNMPs were reviewed during the NMT meetings, other than the aspects related to the diet order and head of bed elevation. PNMPs are reviewed annually at the PSP meeting, and updated as needed. See above. PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results. Clinicians appeared to routinely modify the PNMP as indicated by a change in status. There was little evidence that PNMP monitoring triggered any changes in the PNMPs or staff training, because the prevalence of errors in implementation was significant. There is congruency between strategies/interventions/recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. There was generally congruency between what the therapy clinicians recommended in the annual updates.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan. As cited above, there were a large number of errors related to staff implementation of the PNMP and dining plan. In some cases, staff appeared to know what was supposed	

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	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.	to be provided, but did not use the correct strategies. In other cases, staff did not appear to understand the significance of these errors. Individuals are in proper alignment and position. As cited above, a number of individuals were noted by the monitoring team to be in improper alignment. Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and/or increased risk of aspiration. The intent of the PNMPs and dining plans was that they be followed across all settings. Implementation errors were noted in dining rooms, living areas, and day program areas. In the case of Individual #565, he had been receiving a cookie, inconsistent with his diet order, every week at Bible Study Club. It was not until he choked, requiring the Heimlich, that it became apparent that the Club was "not aware" that he had any diet restrictions. There was significant potential risk of harm to all the individuals participating in that group as well as others. Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. In some cases, when errors were identified by the monitoring team with regard to diet texture, staff were able to verbalize the correct diet texture and rationale. It was of concern, however, that they had not advocated making the correction before serving the food to the individual. Several staff were noted to change what they were doing to correct implementation while being observed. It was of great concern to the monitoring team that these staff appeared to know what they were supposed to do, but had chosen to do something different other than that prescribed in the plan. In other cases, staff believed that they were offering the diet in an acceptable way.	
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.	Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. Foundational training was provided to new employees in the area of physical nutritional management. This training addressed mealtime supports as well as lifting and transfers. Additional inservice training had been provided to all direct support staff with person specific-training to commence in May 2010. As cited above, however, this training had not been effective to address the many problems with PNMP and Dining Plan implementation observed by the monitoring team. Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/posttest, which may also include return demonstration as applicable. By report, skills-based competency check offs were limited to transfers only. Testing related to mealtime consisted of a written test and a mealtime observation using an extensive checklist. All foundational trainings are updated annually. Per the documentation submitted, annual	

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		re-training for physical management was conducted every two years. Other PNM training was not updated annually at the time of this review. Staff are provided person-specific training of the PNMP by the appropriate trained personnel. Habilitation Therapies staff reportedly provided competency-based training for home supervisors and these managers were then responsible to train their staff. Sign-in sheets for inservices provided to DCPs were to be maintained by the home. Staff training provided was not necessarily competency-based. Per the sign-in sheets reviewed, a clinician provided the initial inservice, then the "Home Manager and/or [DCP supervisors] should ensure all staff not present at initial in-service, to READ, DEMONSTRATE COMPETENCY and SIGN." Instructions outlined included techniques, diet order, adaptive equipment, positioning, and so forth. In the case of Individual #16, the SLP provided the initial training on 03/05/10 to the DCP supervisor, who then signed off on competency for an additional four direct support staff. Another staff person signed the inservice sheet, but though there was no signature that she had demonstrated competency, she proceeded to train four additional direct support staff. Another 16 staff had signed the sheet, but were not documented as "competent." Individual #16 was identified at high risk for aspiration and choking and had been reviewed by the NMT on six occasions. It was of concern that competency had not been established for so many staff. On 01/13/10, the SLP, trained another DCP supervisor on Individual #16's dining plan. That staff in turn signed off on the competency of seven additional staff. Four additional staff then trained an additional 13 direct support staff. At least two of these additional staff trainers were DCPs rather than a home manager or DCP supervisor. This practice likely contributed to how the information was improperly conveyed to the staff resulting in the poor performance observed by the monitoring team with regard to implementation of the PNMPs and Dining Plans. PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff that have successfully completed competency-based training specific to the individual. Clinical staff provided inservice training to supervisors and managers. At that time, the supervisor was responsible to complete the training for his or her staff. There was no consistent method used to provide PNM-related training and no consistent method to document that specific competencies were achieved. The type, frequency, or intensity of training did not vary dependent on PNM risk levels. As described above, the DCPs who were inserviced to work with Individual #16, who was at highest risk for aspiration and choking, were not adequately trained to competently implement her plan. Staff are trained prior to working with individuals and retrained as changes occur with the PNMP. Same as above.	

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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.	A system is in place that monitors staff implementation of the PNMPs. On a regular basis (at least monthly), all staff will be monitored for their continued competence in implementing the PNMPs. Extensive PNMP monitoring was conducted by nine PNMP Coordinators. These staff were previously direct care professionals and the Director of Quality Enhancement provided oversight to them and their direct supervisor. None of the completed forms, however, identified the staff providing supports to the individual monitored and, therefore, made the information much less useful than it otherwise might have been. Further, the current plan for monitoring did not systematically ensure that staff were monitored to validate continued competency. In the event that issues were identified from the monitoring, it was reported that the PNMP Coordinators conducted coaching and inservice training. Based on the monitoring team's observations, however, this was ineffective. As stated above, mealtime monitoring completed during a meal was also observed by the monitoring team, but did not reflect any concerns during that meal though many were noted by the PNMP Coordinator. A very limited number of monitoring sheets (less than 20 for January and February 2010) were submitted. It was unclear if that represented only a sample of those completed in the last quarter or that only that few number were completed. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. LSSLC did not submit a policy that specifically addressed the monitoring process. DADS policy #012 Physical Nutritional Management, approved on 12/17/09 with implementation on 01/31/10, was reviewed. It included a section on PNM monitoring which outlined the following: • PNMPs should be monitored as scheduled and as needed by residential supervisors, nursing, therapy, and other professional staff to assess effectiveness of plans and to make changes as indicated • Supervisors should report problems and training needs • Professional staff should monitor for proper use of equipment and intervention strategies; ensure proper implementation and to correct problems • Individuals with identified PNM issues should be monitored regularly by NMT • Daily monitoring of cleanliness, wear and need for repair by direct support staff • Monitoring of equipment at least annually and as needed by therapy staff. There was no policy that outlined frequency or distribution of monitoring based on PNM risk level or any other designation. There were no plans to routinely validate LSSLC	

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		monitors to ensure consistency and accuracy, though this was discussed at length with the PNMP Coordinator Supervisor, QE Director, and the Habilitation Therapies Director. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). At the time of this on-site review, the PNMP Coordinators were assigned caseloads in order to cover all homes. The primary focus of the PNMP tool addressed positioning and transfers, accuracy and availability of the plan itself, and the use and condition of all equipment. Correct use, condition, and cleanliness of equipment were reviewed using the tool, but effectiveness was not. Focus on positioning was limited. It was not apparent that observational monitoring of bedtime and bathing positions were done routinely**.** In many cases, the answer was always that implementation was acceptable. In some, the form was marked "partial," but there were no comments so as to know what the concerns were regarding implementation on that date. There were many elements marked "N/A" indicating that the indicator was not observed. The forms rarely cited an issue with a specific individual. All members of the PNM team conduct monitoring. At the time of this review, the PNMP Coordinators had conducted formal PNM monitoring. In addition, Habilitation Therapies staff, QMRPs, and psychology staff were to complete PNMP and dining plan monitoring. There was no specific plan to aggregate these data and use the data to guide further staff training, coaching, and support. Review of plans outside of the NMT meetings was limited to annual review of status and support plans. In some cases, additional assessment was conducted on a referral basis, as in the mealtime assessment conducted by the SLPs. Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team. The PNM team identified trends, and addresses such trends, for example, to enhance and focus the training agenda. There was no trend analysis of PNMP monitoring or mealtime observations at the time of this on-site review. Plans to do this had not been developed. Moreover, the information obtained from the PNMP Coordinators was not routinely shared with the Habilitation Therapies Director. Thus, it was not surprising that the monitoring team observed individuals eating in improper alignment or with incorrect support during the on-site review. Diet texture or liquid consistency errors were also noted. Validity of this system and of the LSSLC monitors was of concern. This will be a critical element to address regarding training of the new PNMP Coordinators. Immediate intervention is provided if the person is determined to be at risk of harm. There was no system to track this or to follow concerns through to resolution. There was no mechanism to aggregate the data gathered through the monitoring process for use to	

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		focus training needs. As described above, Individual #332's PNMP and Dining Plan had not been modified to reflect a diet texture change months earlier and she subsequently experienced a choking event. Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose. There was no system to track this or to follow concerns through to resolution. There was no mechanism to aggregate the data gathered through the monitoring process for use to focus training needs. System exists through which results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor. By report, unit directors and home managers were notified of issues identified via monitoring. There was, however, no consistent method of documentation to this effect. There were no reports generated to track system change or system improvement on a routine basis. Findings were not routinely shared with the Habilitation Therapies Director. Process includes intermittent internal validation checks to ensure accuracy. No validation checks were conducted at LSSLC at the time of this review by report or documentary evidence submitted.	
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.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. NMT meetings were held monthly to review individuals with regard to aspiration pneumonia, MBS studies, significant weight loss, and follow ups from previous meetings. The approach utilized included a review of previous PNM history and discussion to identify potential recommendations. Follow up was generally consistent, but there were some significant oversights, as described above. Actual trend analysis on a person-specific and/or systemic basis was extremely limited. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. PNMP monitoring was conducted using the PNMP Monitoring Form and focused predominately on staff compliance with implementation of the PNMP, though specific staff were not identified. Monitoring was not person specific, and the frequency of monitoring was not driven in any way by need or risk level. Additional person-specific monitoring by clinicians was generally in response to a request, referral, or identification of a problem rather than as a result of scheduled routine monitoring of health status and the effectiveness of supports to address identified PNM health risk indicators. There was also no mechanism in place to tabulate findings from	

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		follow up monitoring for trend analysis per individual or system wide. A striking example is presented below: • Individual #332's diet order had been downgraded to ground per her OT/PT assessment dated 03/18/09 and 04/06/09 because she did not present with adequate oral motor skills to safely manage the chopped foods. There was a recommendation, however, to continue to permit chopped bread and tater tots for finger feeding. She experienced a choking event on 12/08/09. She had been consistently provided chopped foods because the recommendation for ground foods had never been implemented. It was of grave concern that this individual was at risk for at least nine months due to this serious error and of greater concern was that it took a choking event, placing her at risk of death, before this was noticed by any staff at LSSLC. This exemplified the seriousness of the lack of oversight training and monitoring provided at all levels of supports and services. Numerous others will continue to be at great risk until this issue is remedied. Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted. There was no evidence that the NMT reviewed the findings of PNMP monitoring or mealtime observations to ensure resolution of any identified concerns. The individual's PNM status is reviewed annually at the PSP, and all PNMPs are updated as needed. Annual updates were completed by OT/PT and SLPs. A summary of findings from those reports was included in the PSP. There was generally discussion of the PNMP in the OT/PT/SLP sections of the PSP with recommendations to continue, but recommendations for changes to the PNMP were not consistently summarized. On at least a monthly basis or more often as needed, the individual's PNM status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. There was no evidence in the records submitted of routine monthly review by the PST or members of the NMT. Members of the PNM team complete monitoring system. PNMP monitoring was conducted by the PNMP Coordinators. QMRPs and psychology staff were also to complete monitoring sheets in addition to Habilitation Therapies staff. Immediate interventions are provided when the individual is determined to be at an increased risk of harm. Limited concerns were identified related to improper implementation of plans related to diet texture, dining plan instructions, and position and alignment in the monitoring tools submitted, though a number of these were identified based on the observations of the monitoring team and are described above. It was of	

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		concern, however, that this system was ineffective in ensuring staff compliance, competency, and individual safety, such as the issues identified above. Findings of the PNMP monitors were not shared with the Habilitation Therapies Director.	
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.	All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status. Discussion by the NMT did not specifically address whether enteral nutrition continued to be medically necessary for each person who received it (approximately 49). There did not appear to be a specific discussion of this issue during the PSP annual meeting with other PST members. Clearly, from the numbers of individuals reviewed by the NMT, the team did not review those individuals on a routine basis to determine if enteral nutrition continued to be appropriate. The need for continued enteral nutrition is integrated into the PSP. Issues related to enteral nutrition were evident throughout the PSP with regard to diet order, nutritional assessment, and other medically-related information. There was no evidence that the PST addressed the continued need for enteral nutrition. When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used. In some cases, there was documentation of discussion regarding potential for return to oral intake, for example, Individual #385. There is evidence of discussion by the PST regarding continued need for enteral nutrition. There was insufficient evidence that the PST discussed the individual's condition in order to determine whether enteral nutrition continued to be medically necessary. A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). State policy did not clearly define the depth of assessment required. There did not appear to be a standard for how these assessments were to be completed and there did not appear to be collaboration across disciplines. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. Via PNMPs and Dining Plans, there were strategies designed to address diet texture, liquids consistency, position and alignment, and assistance techniques. As described throughout this review, however, there were numerous examples of inadequate implementation of these plans by staff. The current system of monitoring was ineffective in the identification and remediation of these errors and this put individuals at risk of harm for aspiration and/or choking and increased the potential for tube placement.	

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Recommendations:

1. Include PT staff in NMT meetings; consider closer collaboration with the Health Risk Screening process as well.

2. Ensure increased opportunities for annual continuing education opportunities to include all NMT team members.

3. Establish measurable outcomes and thresholds related to occurrences of risk indicators or identified PNM concerns.

4. Provide a more thorough analysis of objective data to drive a comprehensive approach to interventions. Ensure that consideration is given to assessment of potentials and functional skill acquisition as described in OT/PT and Communication sections of this report.

5. Utilize the monitoring system to fine tune PNMPs and dining plans for consistency and accuracy and to ensure improved staff compliance with proper implementation. Trend analysis of the findings of this monitoring should be utilized to better target staff training. Establish a mechanism in order to routinely, and in a timely manner, provide feedback to the Habilitation Therapies Director regarding all findings of the PNMP Coordinators, QE audits, and other program review methods.

6. Revise current new employee training to ensure that it addresses skills-based competencies rather than only knowledge-based learning objectives. Competency check-offs should include an activity analysis, highlighting the skills necessary to complete the task. Staff should be expected to perform each skill to criteria to achieve competency. Create annual refresher courses with competency-based check-offs to ensure continued competence.

7. All individual-specific training must be competency-based and documented with staff sign-in sheets. Only staff who have been checked off should work with those at highest risk. The current system that trained only one staff, the home manager, was clearly ineffective and the competence of direct support staff for implementation was seriously deficient.

8. Ensure that the PNMP Coordinators receive adequate and appropriate competency-based training, routine review and oversight of the monitoring process in action, and revalidation of competency on a routine basis to promote improved consistency and accuracy. At this time, the process was merely a paper exercise and provided little to ensure that individuals were protected from risk of harm.

9. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency.

10. Consider revision of monitoring tools to better assess staff performance of basic skills. Findings should drive staff training plans. A mechanism to ensure that staff performance related to implementation of PNMPs is systematically evaluated will be critical to ensure continued competency.

11. Conduct trend analysis of all monitoring data. Review findings and make system adjustments.

12. Review staffing and assignments during meals to ensure adequate coverage to provide assistance as prescribed in the Dining Plans. For example, it would not be safe for one DCP responsible for providing one to one physical assistance to one individual to also be required to assist

or provide appropriate prompts and supervision of other individuals at the same time.

13. Review the existing systems of risk assessment to ensure greater integration. Risk levels should be determined by potential risk of harm. Implementation of supports and services to minimize risk do not automatically reduce the individual's potential for risk of harm. The interventions must be effectively in place long enough to attain and maintain stable risk status for a prescribed length of time before risk level is downgraded.

14. PNM review should focus on PNM concerns with follow up through to problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, "Mary will be pneumonia free for six months." Interventions should support achievement of identified outcomes. The NMT should continue to monitor until the individual attains and maintains at the goal level.

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 Current Census Alpha o CVs for PNMT members o Habilitation Therapy Services policy, dated 02/22/10 o DADS policy, Occupational/Physical Therapy Services #014P, 11/04/09 o OT/PT Evaluation template o POI Section P: OT/PT QE Checklists completed by T. Anastasi, 15 forms completed between 01/22/10 and 04/2/10 o Verification of Continuing Education for OTs and PTs o Habilitation Registered Therapists list o OT/PT Evaluations for the following: • Individual #129, Individual #211, Individual #236, Individual #68, Individual #108, Individual #580, Individual #96, Individual #128 Individual #136, Individual #393, Individual #551, Individual #104, Individual #202, Individual #154, and Individual #467, Individual #402, Individual #469, Individual #44, Individual #164, Individual #225, Individual #142, Individual #258, Individual #513, Individual #560, Individual #592, Individual #497, Individual #198, Individual #127, Individual #570, Individual #62, Individual #567, Individual #323, Individual #22, and Individual #565 o OT/PT Activity Plans and Staffing Summaries o PSPs for the following: • Individual #565, Individual #129, Individual #323, Individual #587, Individual #567, Individual #393, Individual #62, Individual #592, Individual #572, Individual #198, Individual #398, Individual #599, Individual #497, Individual #42, and Individual #422 o PNMP format o Dining Plan format o PNMP Monitoring Sheets completed for December 2009 and January/February 2010 o PNMPs submitted for LSSLC individuals o Staff New Employee training curriculum o Meal Observation Sheets o OT/PT Intervention Schedule o PNMP Wheelchair Clinic List o Mat Assessments for: • Individual #536 and Individual #369 o Staff Ratio Data o Wheelchair Data Base, 03/26/10

	o Inventory PT Equipment o Adaptive Eating Equipment list o List of Individuals with Other Ambulation Devices o Lower Extremity and Trunk Orthotic Devices o Primary Mobility Wheelchairs list o Transportation Wheelchairs list o Injuries Sustained by Falls Reporting Period 11/01/09 to 2/08/10 o Individual Record documents including: • Personal Support Plans and addendums • Medical Evaluations for last two years • Nursing Annual and Quarterly Assessments for the last year • X-ray reports for last two years, Nutrition Notes for last 12 months • Communication Assessments/Updates and OT/PT Assessments/Updates for last two years • Functional Eating Survey for last two years • Action Referral notices • Health Risk Assessment Tool • QMRP Professional notes for previous 12 months of PSP • Skill Acquisition Plans for Habilitation Therapies • Incident reports related to falls, transfers, choking, mealtime in the last 12 months • NMT documentation • Wheelchair related assessments • Hospitalizations discharge summaries for last 12 months • ER discharge summaries for last 12 months • Infirmary discharge summaries for last 12 months • Integrated Progress Notes for last quarter • GI consults for last 12 months • PNMP and Dining Plans o For the following individuals: • Individual #560, Individual #554, Individual #561, Individual #549, Individual #513, Individual #44, Individual #353, Individual #225, Individual #466, Individual #570, Individual #22, Individual #202, Individual #174, Individual #321, Individual #1, Individual #565, Individual #334, Individual #10, Individual #458, Individual #535, Individual #332, Individual #137, Individual #521, and Individual #223 <u>Interviews and Meetings Held</u>: o Christina Pedroni, MS, CCC-SLP, Habilitation Therapies Director o Nancy Jo Flournoy, MS, CCC-SLP o Christi Hodges, MS, CCC/SLP o Rhonda Hampton, MS, CCC/SLP o Jeremy McKnight, OTR o Cassi Hairgrove, OTR

	o Sharon Setzer, OTR o Jennifer Burson ,COTA o Jason Burson, COTA o Brenda Webb, COTA o Gail Harris, PT o Tabitha Anastasi, QE Monitor assigned to Settlement Agreement sections O, P, and R o Linda Murley, PNMP Coordinator Supervisor o Barbara Draper, Active Treatment Director o PNMP Coordinators o Meeting with PNMP Coordinators and Active Treatment Director o Discussions with various supervisors and direct care staff o Discussions with various day program staff <u>Observations Conducted</u>: o NMT Meeting 04/21/10 o PNMP Clinic o Mealtimes o Living areas and day program areas
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The existing professional staff demonstrated an earnest interest in the achievement of the elements required by this provision of the Settlement Agreement, but the current systems would likely make that difficult. There were insufficient PT staff to ensure that all individuals received appropriate and timely supports and services. All or most of the therapy clinicians participated in annual assessments in the PNMP clinic, however, this did not appear to be a time and cost effective manner in which to accomplish this and did not always yield an appropriate support plan or appropriate equipment such as wheelchair seating. Of great concern to the monitoring team was the inadequate implementation of PNMPs, particularly related to position and alignment. This may likely be attributed to a number of factors, including poor staff understanding of the principles of alignment and support, inadequate staff training, and the limitations in experience of some of the therapy clinicians. It was very positive to see, however, that LLSSLC had begun to work with two vendors with ATP certification and, hopefully, experience in seating people with developmental disabilities and serious physical challenges. The existing system of monitoring was ineffective in generating appropriate changes in staff compliance and individual health outcomes. The PNMP Coordinators were inadequately trained and supervised. There was no system to track findings and identify trends to guide further supports and training to direct care

	professionals responsible for implementing critical physical and nutritional management supports.

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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.	The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. The census at LSSLC was approximately 411 at the time of this baseline review. The department director, Chris Pedroni, MA, CCC-SLP, was a speech-language pathologist. There was one physical therapist, Gail Harris, PT. By report, the facility had attempted to recruit PTs and PTAs without success. Previously, a PTA had expressed an interest in working at LSSLC, but did not take the position because the salary offered was not acceptable. LSSLC was planning to seek part time contract PTs. OT services were provided by three full-time occupational therapists, Sharon Setzer, Jeremy McKnight, and Cassi Hairgrove, and by three OT assistants, Jennifer Burson, Jason Burson, and Brenda Webb. License numbers were submitted for each clinician. There were 15 therapy technicians. Technicians were assigned to assist in the wheelchair shop, assist the audiologist, take pictures for the Dining Plans provided to each individual, implement TIR (Tone, Inhibition, and Relaxation) programs, take pictures for the PNMPs, provide training, and others duties as assigned. Given the census of 411, it was of concern to the monitoring team that there was only one PT to provide supports and services to all individuals who required these supports and services. Given the mobility level of many of the individuals living at LSSLC, the PT would need to address more acute issues, such as fractures and sports injuries, as well as meet the needs of those who presented with physical challenges. By report, there were four unfilled positions that could be used for OT or PT. With three OTR and three COTA positions filled, the priority would certainly be for PTs or PTAs. The OT and COTA positions, as well as one SLP position, were previously filled via a student stipend program through a local university. There was reportedly a PTA program nearby, but the closest PT program was likely in Houston. By report, the greatest obstacles to filling these much needed positions was competition from nearby home health and rehabilitation agencies, in addition to lower salaries. Fabrication of seating systems occurred on site. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at LSSLC, fabricating custom components, and completing repairs and modifications. At the time of this onsite review, there were three wheelchair technicians and one habilitation technician working in the shop. The facility recently began to collaborate with two durable medical equipment vendors each with a certified Assistive Technology Professional (ATP). This appeared to be an adequate amount of staffing resources for	

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		these tasks. All individuals have received an OT and PT screening. If newly admitted, this occurred within 30 days of admission. Screenings were not conducted, but instead, full baseline OT/PT assessments were provided for those newly admitted to the facility. These assessments were integrated assessments completed by the physical therapist and an occupational therapist, and signed by both. Five assessments completed by each clinician were requested by the monitoring team as well as the most current OT/PT assessments within the last two years for a number of individuals for whom personal records were requested. The PT participated in the 30 assessments reviewed. Cassi Hairgrove, OTR, had participated in 16 assessments submitted. Jeremy McKnight, OTR, participated in 26 of the assessments submitted. Both of these OTRs participated in 11 of the assessments reviewed. All assessments were current within the 12 months prior to this review. These assessments were identified as Evaluation Updates (14) or Staffing Updates (16) and were of different, yet similar, formats, though the formats used were consistent across clinicians. The Evaluation Update generally appeared to be more comprehensive than the Staffing Update. Each was an update to a previous update or evaluation and completed prior to the annual PSP staffing. It was unclear to the monitoring team, however, whether these different updates served different purposes in the development of each individual's plan. Assessment detail and clinical reasoning also varied greatly from report to report. Though identified as a "summary," this section typically provided a rationale for the recommendations that followed. Per the Evaluation Update for Individual #96, dated 02/21/10, it was an update to her Admission Evaluation in 2007. It was not possible to determine the date of her admission to LSSLC from the documents submitted. She had not received direct services, but rather supports, such as a PNMP and special assessments related to mechanical lift transfers and functional ambulation status during the last year. Though this element was not specifically evaluated for recent new admissions during this baseline review by the monitoring team, this will be investigated further in subsequent monitoring team reviews. All individuals identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. By report, new issues that required additional assessment by OT or PT were generally addressed well within the 30 day period by report. While it was not possible to effectively evaluate this element during the baseline review, further investigation of this will be conducted in subsequent reviews.	

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		If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status. Per the PNM Handbook developed by Karen Hardwick, Ph.D., OTR, FAOTA, and updated in 2010, the comprehensive assessment was completed upon admission to the facility and updates were completed annually thereafter when supports and services were provided to the individual. There was not a clearly delineated comprehensive baseline assessment with interim updates, but rather the evaluations submitted were each "updates" to a previous update. For example: • The Evaluation Update for Individual #570 dated 05/19/09 was identified as an update to an Evaluation conducted in 1997 and subsequent Updates were completed in 2000, 2003, and 2006. • Individual #513 had received an Evaluation in 1996 with subsequent updates in 1999, 2002, and 2005 per the assessment dated 04/30/08, with another update in 2009. • As noted above, Individual #570 had received an Admission Evaluation in 2007 with no further assessments or updates since that time until March 2010, despite the fact that she had gastrostomy tube placement in 2008, aspiration pneumonia, and a reported decline in function. It was reported that she was specifically assessed per physician order to evaluate for mechanical lift transfers in September 2009, June 2009 related to functional ambulation status, and also related to head of bed elevation secondary to gastrostomy tube feedings. It was of concern, however, that a thorough comprehensive assessment had not been conducted post-tube placement, and at least annually since admission given her significant physical and nutritional support needs. The assessment conducted in PNMP Clinic during the week of the monitoring team's review was observed and is described below. There were a large number of clinicians (PT, three OTRs, COTAs) present, though not all of them fully participated in the assessment, and the room was very small and crowded. Even so, the assessments were not thorough and comprehensive. • Individual #513 appeared in the clinic positioned in a sling seat and back in severe posterior tilt, thoracic kyphosis, and the arm rests were up under his armpits. He was not assessed in his current wheelchair intended for long distance use only prior to transfer to the mat table. The only issue identified was that he needed swing-away footrests. It was of concern to the monitoring team that this inadequate seating device had not been previously identified as an issue and, moreover, that the team had waited until time for his annual PNMP review to address it. • Individual #570 was noted to be leaning in his wheelchair and the team discussed the need for lateral trunk supports rather than assess the alignment and support to his pelvis. Individual #570 was followed in Wound Clinic	

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		secondary to skin breakdown on his left greater trochanter. The assessment process observed on this date was incomplete and would potentially impact the appropriateness of supports and services that he would receive. Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral. By report, if an individual did not have equipment or supports, he or she was evaluated at least every three years. This standard was not specifically reviewed because the sample did not include individuals who did not receive some level of therapy supports and services. For example, all individuals were to be provided a PNMP and a dining plan. All of the individuals included in the sample received some level of support by OT and/or PT. Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment. Per the baseline assessments/updates reviewed and lists submitted, there were approximately 128 individuals who required the use of a wheelchair as their primary means of mobility. Another 48 individuals used a wheelchair for transport only and approximately 42 individuals used some type of assistive device for ambulation. In most of the reports, there was a statement as to whether the wheelchair met that individual's transportation and positioning needs. The annual assessment and PNMP review in PNMP clinic resulted in referral to the SPOT clinic for further evaluation of seating systems as indicated. While this was an appropriate time to review each individual's needs, it should not be a substitute for routine monitoring with timely identification of concerns throughout the year and not merely in preparation for the annual meeting. Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. A discussion of health status, hospitalizations and relevant consults and diagnostics was included in the assessments reviewed. Most did not include a list of medications. Service objectives outlined in the updates addressed specific risk indicators. It appeared that concerns were addressed as they came up, but appeared to be largely based on referrals rather than triggered via routine monitoring and proactive identification of needs. An example is presented below. • Individual #223's mother expressed concerns to the therapists on 03/31/10 about his scoliosis and his tendency to lean to the left per the integrated progress notes. Mother also requested that he be positioned in left sidelying while in bed. The OTR and mother agreed that additional padding would be added to the left side of his foam-in-place system to align his trunk more	

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		optimally. Without a more comprehensive mat evaluation and assessment of his current seating, merely adding extra padding may serve only to be a temporary and superficial fix, rather than an effective long-term solution to this mother's concern. Fortunately he was referred to the wheelchair clinic to modify his wheelchair and "possibly fabricate a left sidelyer if Individual #223 was able to tolerate this position." Two weeks later, it was documented that he was seen in wheelchair clinic. It was determined that he needed to have a new molded system to effectively support him in his wheelchair. There was no mention of consideration for left sidelying in this note. It was of concern that if this individual's mother had not advocated for him, he would have continued to be seated inadequately. The current system was delivered on 02/12/09 and he had received an OT/PT assessment dated 05/26/09. It was reported that he should not be placed in left-sidelying, but there was no rationale provided in the assessment. It was a concern that there was no evidence that his bed positioning had been re-evaluated at this time. Documentation submitted was for the quarter preceding this on-site review, so it could be determined if he had received additional services from OT/PT since his annual evaluation. He presented with a diagnosis of chronic sleep apnea and it appeared that he spent much of his day in bed. Alignment and support in bed would require careful assessment to determine impact and potential risks and benefits to current respiratory status. Clearly, the current system of monitoring and review was inadequate to effectively identify needs of the individuals who required supports and services. <u>Evidence of communication and or collaboration is present in the OT/PT assessments</u>. OT and PT completed a combined assessment report. At times, the SLP participated in the assessment clinic and a section related to oral motor skills was included in the written report. A separate communication assessment report, however, was generated with audiology. The assessment process was observed by the monitoring team. Aspects of the process appeared to be effective, though there were many clinical staff in the very small assessment area, but only a few clinicians actually participated in the assessment. With serious challenges facing the department related to the Settlement Agreement, it was not the most effective use of professional staff time. The value of professional exchange and cross training was not evident, and little was contributed to the actual outcome for the individual evaluated. The value of opportunities for this kind of experience was recognized by the monitoring team, but the process should be organized, with clear expectations for participation and may be better served as a scheduled event for complex assessments or as a peer review process, and not on a routine basis for each and every assessment completed.	

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P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Within 30 days of a comprehensive assessment, or sooner as required for health or safety, a plan has been developed as part of the PSP. Plans developed were generally limited to PNMPs and Dining Plans. Plan development was the responsibility of habilitation staff and, in the case of PNMPs and dining plans, implementation was by direct care professionals. By report, all plans were in place and when a revision was necessary, each of the plans was modified. The date on the PNMPs was changed with highlights added to the changes made to the plan. There was currently an effort to provide Dining Plans to all individuals at LSSLC, though the projected target date of completion was scheduled for 2011. Within 30 days of development of the plan, it was implemented. Though PNMPs were in place with staff training reported, many were not appropriately implemented by direct care professionals and PNMP monitors. For example, transfers were observed with staff using poor body mechanics and individuals were not repositioned after the transfer to appropriately align them in their wheelchair or other positioning equipment (e.g., Individual #549). PNMP monitors and DCPs transferred her from her wheelchair to the Versaform on the mat table. Her plan pictured that pillows should be under her legs for support, but these were not available. She was not properly aligned and supported, and her legs were extended with pressure into her feet on the mat table. Staff partially corrected her alignment after being questioned by the monitoring team. Another example included Individual #10, who was observed in a prone positioning. Pictures in her plan showed that she should wear ankle weights to keep her legs straight, and with folded sheets and pillows to maintain her hip and lower extremity alignment. She was not wearing ankle weights and the pillow and sheet were not in the appropriate place. Both of her legs were in flexion rather than straight. The therapeutic value of this position was questionable, even as designed in the plan. Appropriate intervention plans are: a. Integrated into the PSP; b. individualized; c. Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and c. Contain objective, measurable and functional outcomes. Review of PSPs revealed that recommendations for adaptive equipment identified in the PNMP were listed in the OT/PT assessment section of the document and generally again as a service objective in the Action Plan section of the PSP. In addition, there were no objective, measurable, and functional outcomes with established criteria associated with direct therapy interventions, though the summary contained in the assessments generally identified a rationale for interventions and supports. For example, activity plans documented only service objectives that the individual would receive range of motion to all four extremities by a licensed therapist or therapy assistant (Individual #232) or that the individual would participate in flexibility activities to bilateral lower extremities (Individual #75). This plan was implemented by a	

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		habilitation technician. The data collected on each of these types of plans was attendance only. In the case of Individual #232, his OT/PT assessment dated 10/27/09 and 11/04/09 stated that there had been no documented or reported changes in his tone or range of motion during the previous year, but there were no data offered to support this statement and it was unclear what the specific concern was for Individual #232. At LSSLC, so few individuals received direct services from licensed therapists, so it was surprising that there was insufficient evidence of why this individual received direct service from an OTR and/or COTA five times every week. His health status did not appear to be of greater concern than many of the other individuals with significant PNM concerns based on the current OT/PT assessment. In the case of Individual #75, his activity plan was to be changed to a "tone, inhibition and relaxation" (TIR) program as of April 1, 2010, though there was no rationale offered for this change. His assessment dated 08/11/09 stated that the flexibility program was necessary to minimize further contractures. It was unclear how the effectiveness of this intervention was to be determined. The service objective review for March 2010 stated that he continued to participate in the program at a level sufficient to "maintain optimal physical level," yet it was not recommended that it continue, and instead be replaced by the TIR program. <u>Interventions are present to enhance: a. movement; b. mobility; c. range of motion; d. independence; and e. as needed to minimize regression</u>. Interventions provided were largely in the form of supports via the PNMPs. A number of direct interventions were provided by the PT for acute concerns. Other interventions were provided by COTAs, OTRs, and PT for range of motion, movement, "trunk," and other interventions for approximately 32 individuals. Approximately 85 individuals participated in the TIR program to address muscle "tone, inhibition and relaxation," based on a continuing education program attended by the clinicians. Apparently this program had recently been updated to also include functional activities. Activity Plans were developed and techs wrote a note as to whether the program was completed; then a licensed clinician monitored progress monthly and documented findings on a progress note sheet. There was, however, no clear establishment of baseline status and limited reporting of progress or evidence of maintenance in the updates reviewed as described above. For example, per her evaluation update on 12/30/09, Individual #104 participated in "flexibility programming" five times per week to maintain joint mobility. It was stated that there had been no changes in her tone or range of motion in the last year. Based on observations of handling by the OT during an assessment (Individual #513) observed by the monitoring team, it would not have been possible to make these determinations by briefly moving the individual's right arm as noted at that time. There was no reference to previous range of motion measurements to ensure that this was unchanged.	

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		It was of further concern that interventions and expected outcomes were not function-based, but were intended to only address system impairments such as limitations in range of motion or increased muscle tone. It is generally known in therapy practice that range of motion exercises alone have little impact on actual motor function. Range of motion at the shoulder and hip should be integrated with functional activities and other assisted movement to promote greater trunk mobility, such as rotation and lateral flexion to be fully effective. While range of movement may be important to address skin integrity issues, for example, rather than to promote active movement, this rationale must be identified, and a specific reference as to how effective the intervention is to address the intended PNM risk or concern, must be well documented. It will be critical that the Habilitation therapists carefully establish priorities and focus their efforts on those that will have the most significant impact on the health status and functional performance of the individuals they serve. The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used. Each of the PNMPs reviewed listed specific assistive technology and equipment to address the individual's needs. As stated throughout this report, however, the proper implementation of these devices was inadequate. See examples below. Therapists provide verbal justification and functional rationale for recommended interventions. Assessments reviewed generally provided a verbal description of the rationale for recommended interventions that were then integrated into the PNMP and listed in the PSP. Most of the activity plans were related to passive range of motion. There was, however, no well-established rationale for these programs, as described above. Also as noted above, one activity plan was replaced without sufficient rationale. On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. The activity plans were reviewed monthly, but the data maintained was attendance, and the comments were focused on whether participation was sufficient to continue, and no specific data related to performance, health status were provided as rationale for the program to continue. PNMP monitoring was conducted by the nine PNMP Coordinators, most of who had started in this role within the last three months. Chris Pedroni, the Habilitation Therapies Director did not receive a summary of findings by the monitors or notification that concerns had been identified by a PNMP Coordinator. When an issue was identified, a written report/email was provided to the Unit Director and Home Manager who in turn responded via email.	

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		In addition, there was no system of routine review of PNMPs for effectiveness other than annually at the time of the assessment or when a referral or request was received. The monitoring system did not effectively address concerns as evidenced by the numerous errors in implementation of these plans. The system was predominately problem oriented rather than preventative in nature, and it appeared that most of the needs were identified and addressed via referrals or at the annual assessment only, rather than throughout the year. There was no current system to reflect routine review of the effectiveness of any changes that were made.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	Staff implements recommendations identified by OT/PT. As described above, there were numerous instances of incorrect implementation of Dining Plans. In addition, staff implementation of positioning plans and alignment guidelines was inadequate, or alignment and support was insufficient for safe and optimal function. The monitoring forms submitted failed to identify improper implementation of PNMPs. Examples of improper implementation of positioning plans and generally accepted position and alignment guidelines are presented below. • Individual #369 was observed sitting with her head in hyperextension and turned to the left. • Individual #22 was observed seated in a severe posterior tilt and significant thoracic kyphosis. His legs were shifted to the right and his feet were not well supported. By report, he vomited after he ate due to his leaning over. Direct support staff indicated that he was to have a head strap to prevent this, but it had not yet been provided. • Individual #361 was observed with her left leg and foot not on the foot rest for proper support and she was rotated to the left. • Individual #467 was observed with her head/neck in hyperextension. • Individual #597 was observed with her head turned to the right and her right arm was across her chest on her neck. Her seating system appeared to be too small. • Individual #521 was observed with her head flexed forward and leaning to the left. Her shoulders did not contact the upper back of her wheelchair seat. Her lower extremities were in extension. • Individual #96 was leaning to the left and staff used two pillows to prop her up. By report, they had been doing this for a number of months. • Individual #560 was lying on a pressure relief mattress in her hospital bed. The head of the bed was elevated, but she was very low in the bed and was not appropriately positioned. The nurse called for DCP staff to reposition her after this concern was brought to her attention by the monitoring team. There were no pictures in her PNMP to guide staff to properly align and support her in her	

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		bed. • Direct support staff did not attend to position and alignment for those seated in recliners. • Individual #430 did not have foot support and he was seated in a wheelchair with a sling seat and back. • Direct support staff assisting Individual #450, did not provide adequate time to position his feet on the floor to permit weight bearing during the stand pivot transfer. • Individual #406 was lifted rather than permitted to bear weight on his legs during his transfer. • Individual #225 was not positioned back in her wheelchair; her thighs were angled down and inadequately supported on the seat. • Individual #353 was leaning to the left and her arm was positioned inside the armrest. Her hips were not back in the seat and were shifted to the right and her legs were shifted to the left. Her feet were not supported. There were no pictures of her in the correct position in her PNMP book. • Individual #515 was not cued by staff before the transfer. She was seated in a recliner with her gait belt on very tight across her chest. She was receiving oxygen at the time. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations</u>. The only competency-based training aspect of new employee orientation provided in the area of OT and PT supports was related to lifting and there was a check-off list related to mealtimes. Training in other areas of new employee orientation relied on written test questions and classroom participation. Person-specific training was provided to home managers and, by report, was competency-based. Home managers were then responsible for the training of staff assigned to their home. Informal coaching of staff was supposed to occur as an aspect of PNMP monitoring when concerns were noted. As described below, this was not consistent and the PNMP Coordinators were not adequately trained to competency themselves. <u>Staff verbalizes rationale for interventions</u>. Staff were generally not able to recognize when an individual was not in adequate alignment. This was evidenced by the number of individuals observed by the monitoring team in improper alignment during this on-site review. As such, staff clearly were not able to identify the rationale for such interventions. As described above, numerous errors were noted with regard to food texture and liquids consistency as well as mealtime adaptive equipment prescribed on the PNMPs. Staff did	

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		not re-position individuals prior to mealtime and were clearly unable to identify the importance of proper alignment for safety to ensure adequate nutrition and hydration, and to promote independence.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	System exists to routinely evaluate: a. fit; b. availability; function; and c. condition of all adaptive equipment/assistive technology. Home staff and PNMP monitors were responsible for identifying concerns related to adaptive equipment and assistive technology. As described below, this system was marginally effective. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. At the time of this review, DADS policy #014 Occupational/Physical Therapy Services addressed monitoring by mandating that a system be implemented that addressed: 1. the status of individuals with identified occupational and physical therapy needs 2. the condition, availability, and appropriateness of physical supports and assistive equipment 3. the effectiveness of treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual 4. the implementation of programs carried out by direct support staff. There was no formal policy regarding how this monitoring system should be implemented with regard to frequency or how to follow up in the case that issues were noted during this process. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. The current system of monitoring did not specifically target review of staff competence. The current system was more person-specific and did not identify the staff providing supports at the time the monitoring was conducted. There was no mechanism in place to track the frequency or findings through formal review of competency for staff. As described above, one PNMP monitor did not identify any of the concerns noted by the monitoring team during one meal observed. For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. All new employees attended training related to physical management as an aspect of the new employee orientation. Documentation submitted by LSSLC indicated that 100% of staff had received this training. It was unclear if that was referring to all new employees or also included existing staff. There were no DCPs who had been employed for many years who would not have received the most current	

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		training and no refresher training to ensure effective PNMP implementation. Sign-in sheets were not requested related to person-specific training for transfers and lifting during this on-site baseline review, so further assessment of implementation and documentation of this system will be necessary in the future, however, based on observations noted by the monitoring team, the current system of training and review of staff performance was inadequate. <u>Responses to monitoring findings are clearly documented from identification to resolution of any issues identified</u>. There was an area on the monitoring sheet to document a plan of correction on the form in order to track problem resolution. This was not generally completed by the PNMP monitors. There was no clear method, other than report by the PNMP Coordinators, to bring a concern to their supervisor's attention who then sent an email to the Unit Director and Home Manager, but not to the Habilitation Therapies Director. There was no tracking or trending of issues identified. <u>Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available</u>. The current system was primarily reactionary, with staff reporting a problem rather than a proactive system that quickly and routinely identified missing and dirty equipment, as well as repair and preventative maintenance needs. By report, basic wheelchair checks were conducted routinely to identify maintenance and issues related to cleanliness, in addition to the physical management plan monitoring conducted by the nine PNMP Coordinators. There did not appear to be a specific schedule for this to ensure that individuals considered to be at higher risk were monitored with greater frequency. The PNMP Coordinators were assigned a caseload of individuals to be monitored. At this time, however, there was no established tracking system to determine how consistently this schedule was implemented. During the assessments observed by the monitoring team, each individual was to have orthotics, but arrived at the assessment without them. The monitoring team further observed cases in which the appropriate adaptive equipment was not available. Some examples, included: • Individual #597 was observed during a medication pass when the nurse administering her medications presented crushed medications on a tongue blade and poured liquids into her mouth with a paper cup. These were clearly not her adaptive mealtime equipment (plastisol teaspoon and crystal cup with snorkel lid) per her PNMP/Dining Plan. • Individual #96 was observed seated in her wheelchair with two pillows on her right and left sides to support her arms. Staff reported that without the pillows, she leaned over in the wheelchair. There were no lateral supports on her chair. When DCP staff was asked about how they were to report these concerns, they	

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		stated that they were to inform the Wheelchair Shop. The DCP staff indicated that this had not been reported and that Individual #96 had been propped in that manner for many months. • Individual #388 was seated in wheelchair that was very rusty. Her legs were crossed left over right, and she was not seated fully back in the seat. • Individual #454 was seated in a sling seat and her toes were just touching the ground. If she self-propelled this chair with her feet, it was too high for her to do so effectively, and she did not have sufficient support to her legs and feet. • Individual #108 was to use a dycem mat while eating and this was not available to him until direct support staff was cued by the monitoring team. • Individual #450 was to use a footstool for foot support during meals. This was not provided to him and he was not seated in a dining chair as prescribed in his PNMP. • Individual #296 was to wear bilateral upper extremity splints. These were not properly applied per the picture in her PNMP. Finger separators in use were not included in the PNMP. Professional staff contacted to attend to this did not appear to know how to correct the problem. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs</u>. It did not appear that the current system of monitoring adequately addressed issues related to the effective implementation of the PNMPs. Numerous implementation errors were noted by the monitoring team, but most of the completed PNMP monitoring forms did not identify any concerns. Forms submitted represented monitoring completed for the months of December 2009 through February 2010. Monitoring was completed across homes and at various times of day. There were 13 monitoring forms submitted as completed in February, three in January 2010, and two in December 2009. It appeared that the majority of this monitoring was conducted prior to 2 p.m. and 50% was completed prior to 12:00 PM, rather than a strong sample across all shifts. Only one was completed after 2:10 PM in all the months submitted. There was no aggregation of data in order to trend the findings of the PNMP Coordinators, however, it was apparent from the forms submitted, that finding an issue with PNMP implementation was more the exception than the rule. Observations by the monitoring team cited numerous issues related to implementation of positioning plans and dining plans. Often, even if there was a "no" answer or "partial" answer, there was no description to identify what the concern had been. If an issue was not identified clearly, the PNMP Coordinators could not provide training or coaching with significant frequency, or clinicians would be unable to resolve specific problems and as a result, the	

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		system would not effect change in compliance with PNMP implementation. Data collection method is validated by the program's author(s). There were no interventions implemented that involved data collection. By report, attendance was recorded by the habilitation technicians for the TIR program and the licensed clinicians documented status in a monthly progress note. There was no evidence that the program authors reviewed the implementation of the program to ensure it was being done as designed.	

Recommendations:

1. PT staffing must be increased to ensure that all elements of the Settlement Agreement can be implemented and sustained.

2. Training of PNMP Coordinators must be competency-based to include didactic presentation of content information necessary to recognize issues related to PNM, as well as hands-on opportunities to practice necessary skills. This must include monitoring strategies, follow-up steps, documentation, and interaction with staff and supervisors, as well as hands-on opportunities to complete the monitoring form and, in addition, validation by a licensed clinician to ensure accuracy and consistency. Documentation should verify successful performance of all skills-based competencies. Minimum criteria should be established and independent monitoring should not be permitted for each PNMP Coordinator until those criteria are met. Routine monitoring of the PNMP Coordinators should be conducted to validate continued competency. These staff must be able to properly demonstrate implementation of each of the elements of PNM in order to successfully model for and coach direct support staff.

3. The monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded, and addressed with documentation of problem resolution. Each identified concern must be addressed via a mini-plan of correction with evidence of completion such as staff training, submission of work order, equipment replacement, and so forth. Full disclosure must be routine via sharing all findings with Habilitation Therapies.

4. All monitoring results must be tabulated for trend analysis to identify systems issues to guide training and follow up, as well as to celebrate areas of excellence.

5. All staff training must be competency-based and is recommended to include specific steps and skills required to successfully execute plan implementation. Checklists developed should be used to guide training with demonstration, practice, and return demonstration to establish competency and subsequent rechecks for continued compliance.

6. Examine the process of team assessment that includes all the clinicians in one assessment with one individual. While the interaction can be valuable, routine participation by every clinician in this lengthy assessment process would likely take away from other necessary activities required for compliance with the Settlement Agreement.

7. Quality improvement of seating assessment must become a focus to ensure that outcomes result in optimal support and alignment for

individuals.

8. Staff training related to position and alignment must occur with significant intensity to ensure appropriate and consistent implementation of PNMPs.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o Reviewed dental records for individuals listed in section M. o Reviewed the following additional documentation for individuals listed in section M: • TIVA Justification Narrative • Dental Clinic TIVA Data • TIVA Consents o Reviewed Health Management Plans for oral hygiene for individuals listed in section M. o Oral Healthcare for People with Special Needs: Guidelines for Comprehensive Care, dated 2004. Interviews and Meetings Held: o Dr. Louis Kavetski, DDS, dentist, and the dental staff: • Dr. Tina Murray, DDS • JoAnne Lancaster, full time hygienist • Marrill Gerth, half time hygienist • Evelyn Barnes, full time dental assistant Observations Conducted: o Dental clinic area
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: LSSLC had a group of committed, talented, and motivated dental staff. They were on the right track in terms of their goals for the department (e.g., proper dental care provided by dental staff, staff trained to teach and assist individuals with daily oral care, implement the least intrusive interventions). The director of the department had only recently been hired into that position. Although not yet meeting the requirements of this Settlement Agreement provision, the monitoring team is optimistic about the department's ability to improve dental services. State policy needed to be developed and subsequent to that, facility policies need to be developed. The facility also needed to incorporate the guidelines as indicated in provision Q1 regarding published dental guidelines. The state had provided a copy of a document called, "Oral Healthcare for People with Special Needs." This was not yet being addressed at LSSLC.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	Although LSSLC was not yet meeting the requirements of this provision, recent changes in the dental services department led the monitoring team to expect improvements to continue to occur before the next onsite monitoring visit. Dr. Kavetski has directed the dental department at this facility for only the past five months. In addition to the director, the department included another half-time dentist, a full-time and a part-time dental hygienist, and a dental assistant. The dental assistant had 30 years of experience at LSSLC. Dental had been working with the units to improve oral hygiene, and one of the indicators observed was the number of health management plans for oral hygiene. These had increased and indicated that good work was beginning to occur. TIVA (total intravenous anesthesia) was beginning to occur at least two days a month at the facility, designed for use with persons who would not allow dental care even with sedation. The requirements for documentation and informed consent for TIVA were progressing nicely. The dental anesthesiologist, Dr. James Chancellor, also provided services at three other state facilities. With this change, the dental department had eliminated physical restraints, and use of restrictive devices, such as papoose boards. TIVA had been running for nearly a year, and five individuals were seen for each of two sessions a month. For many individuals, this had been the first time the dental department had been in their mouths and the dentist completed as much treatment as possible while they were under anesthesia. Primary treatment issues had been getting consent from LARs who were not always responsive when consent or other documentation was required. That had caused treatment delays for some individuals, but the department reported that the social workers were very good about following up with LARs. When there was no legal guardian, there was a process for the facility to provide consent with three physicians and the facility director following the facility requirements to provide consent. At the time of the onsite tour, 61 individuals had been treated under TIVA. The department had activated a dental desensitization program using the Positive Assessment of Living Skills. Although this program had just begun, there was a specific set of activities to prepare individuals to come to the dental suite, sit in the chair, and tolerate oral hygiene. The dental staff commented that this was effective for many of the individuals and that they (the dental staff) were able to see the inside of the mouths of these individuals for the first time and they were able to do at least some treatment.	

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		The department had a program for Oral Health Maintenance. The department had a "disclosing program." Nurses were using two-tone medium, which would turn navy blue or dark, dark blue, depending on the type of plaque present in the mouth. Frequency of recall varied by the needs of the individual. Most individuals were scheduled twice a year, but the department had individualized this frequency based on the individual needs of the person. The dental department director noted, during a meeting with the monitoring team, that, in his opinion, they were are on the road to satisfying one of their major challenges, that is, routine oral care. They were working towards helping the individual learn to do it by himself or herself, or with staff assistance. The dental department would prefer to improve the level of care that is provided through desensitization without having to take the person all the way to TIVA. Most of the innovation in this department was in its beginning stages, but there was a level of enthusiasm and a commitment to quality that should assist the dental department to meet the requirement of the Settlement Agreement within a reasonable period of time.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals'	A state policy developed by DADS had not yet been completed. It is expected that this new policy will provide direction to the facility regarding this Settlement Agreement provision. It was the understanding of the monitoring team that a document titled, "Oral Healthcare for People with Special Needs: Guidelines for Comprehensive Care" that was published in 2004 would serve as a standard for dental services provided at all of the facilities. More work will need to be done between the facility and DADS to determine how to interpret and implement those published guidelines.	

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	refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.		

Recommendations:

1. Develop and implement state policy.
2. Align LSSLC policies with the state policy.
3. Determine how to incorporate the contents of the document "Oral Healthcare for People with Special Needs" as noted in section Q1.
4. Work with LSSLC psychologists, psychiatrists, and staff who write and monitor skill acquisition programs to ensure the best possible methods are being used to teach independent dental care, train staff on providing that care, and make the desensitization programs as effective as possible.

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 Current Census Alpha o CVs for PNMT members o Habilitation Therapy Services policy, dated 02/22/10 o DADS policy, Communication Services #016, 10/07/09 o Speech-Language Evaluation – Baseline template (POR-MR-9, 99/02) o POI Section R: Communication QE Checklists completed by T. Anastasi, 15 forms completed between 01/22/10 and 04/12/10 o Verification of Continuing Education for SLPs o Habilitation Registered Therapists list o Speech-Language Evaluation template o Speech-Language Evaluations for the following: • Individual #129, Individual #42, Individual #422, Individual #398, Individual #554, Individual #497, Individual #572, Individual #128 Individual #221, Individual #294, Individual #453, Individual #344, Individual #57, Individual #370, and Individual #84, Individual #36, Individual #269, Individual #288, Individual #459, Individual #134, Individual #511, Individual #573, Individual #267, Individual #248, Individual #506, Individual #333, Individual #300, Individual #545, Individual #503, Individual #92, Individual #471, and Individual #232 o Communication Activity Plans and Staffing Summaries o PSPs for the following: • Individual #565, Individual #129, Individual #323, Individual #587, Individual #567, Individual #393, Individual #62, Individual #592, Individual #572, Individual #198, Individual #398, Individual #599, Individual #497, Individual #42, and Individual #422 o PNMP format o Dining Plan format o PNMP Monitoring Sheets completed for December 2009 and January/February 2010 o PNMPs submitted for LSSLC individuals o DADS policy, Occupational/Physical Therapy Services #014P, 11/04/09 o Communication Skills Therapeutic Equipment, 03/30/10 o Staff New Employee training curriculum "Interactive Communication" o Meal Observation Sheets o Individual Record documents including: • Personal Support Plans and addendums • Medical Evaluations for last two years • Nursing Annual and Quarterly Assessments for the last year • X-ray reports for last two years, Nutrition Notes for last 12 months

	• Communication Assessments/Updates and OT/PT Assessments/Updates for last two years • Functional Eating Survey for last two years • Action Referral notices • Health Risk Assessment Tool • QMRP Professional notes for previous 12 months of PSP • Skill Acquisition Plans for Habilitation Therapies • Incident reports related to falls, transfers, choking, mealtime in the last 12 months • NMT documentation • Wheelchair related assessments • Hospitalizations discharge summaries for last 12 months • ER discharge summaries for last 12 months • Infirmary discharge summaries for last 12 months • Integrated Progress Notes for last quarter • GI consults for last 12 months • PNMP and Dining Plans o For the following individuals: • Individual #560, Individual #554, Individual #561, Individual #549, Individual #513, Individual #44, Individual #353, Individual #225, Individual #466, Individual #570, Individual #22, Individual #202, Individual #174, Individual #321, Individual #1, Individual #565, Individual #334, Individual #10, Individual #458, Individual #535, Individual #332, Individual #137, Individual #521, and Individual #223 <u>Interviews and Meetings Held</u>: o Christina Pedroni, MS, CCC-SLP, Habilitation Therapies Director o Nancy Jo Flournoy, MS, CCC-SLP o Christi Hodges, MS, CCC/SLP o Rhonda Hampton, MS, CCC/SLP o Jeremy McKnight, OTR o Cassi Hairgrove, OTR o Sharon Setzer, OTR o Jennifer Burson ,COTA o Jason Burson, COTA o Brenda Webb, COTA o Gail Harris, PT o Tabitha Anastasi, QE Monitor assigned to Settlement Agreement sections O, P, and R o Linda Murley, PNMP Coordinator Supervisor o Barbara Draper, Active Treatment Director o PNMP Coordinators o Meeting with PNMP Coordinators and Active Treatment Director o Discussions with various supervisors and direct care staff

	o Discussions with various day program staff Observations Conducted: o NMT Meeting 04/21/10 o PNMP Clinic 04/20/10 o Mealtimes o Living areas and day program areas
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The speech and language department maintained the PSP assessment schedule and provided Activity Plans and some limited direct service for individuals at LSSLC. The clinicians rotated assessment responsibilities as they came due, according to the PSP schedule. While the caseloads were in excess of 130 individuals for communication and mealtime issues, there was a student graduating in May 2010 who planned to complete her Clinical Fellowship Year at the facility. This fourth SLP would contribute to better balance the heavy caseload and the responsibilities of implementation of the provisions of the Settlement Agreement. There were a very limited number of AAC devices assigned to individuals with many more who would benefit. Controversy around whose responsibility it was to provide equipment and supports for AAC systems was a barrier to timely and effective implementation of much needed programs at LSSLC. Communication by individuals at LSSLC occurs round the clock and is the responsibility of all staff. It appeared that there was a separation of those who needed AAC from those who communicated verbally. The SLPs can conduct evaluations and can serve as direct providers of services, as well as a consultant to day programs, homes, and work environments to ensure that all staff step up and capitalize on the communicative efforts of those who are most in need of alternative methods to express their needs and wants. The idea of waiting until the individual has mastery of a communication system before it becomes integrated into his or her daily life and routine will result in failure to provide the necessary supports to enhance communication and quality of life. This barrier must be addressed via open dialogue, staff training and collaboration in order to meet the expected outcomes of the Settlement Agreement.

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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	The facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience. At the time of the on-site tour, there were three full time speech and language pathologists with clinical responsibilities. Nancy Flournoy, MS, CCC-SLP, and Christi Hodges, MS, CCC-SLP worked Monday through	

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	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.	Friday, and Rhonda Hampton, MS, CCC-SLP worked Tuesday through Friday. A stipend student was to graduate in May of this year and had plans to begin her Clinical Fellowship Year (CFY) at LSSLC. It was anticipated that she would become a staff SLP upon completion of her CFY clinical hours. There was one habilitation technician assigned to speech and one other to audiology. The Director of Habilitation Therapies was Christina Pedroni, MS, CCC-SLP, also a speech-language pathologist. She became a staff SLP at LSSLC in October 2008. She assumed her current role in August 2009 as the Acting Director, upon resignation of the previous Director of 15 years. Ms. Pedroni was subsequently appointed as Director as of 11/1/09. The number of speech clinicians was of concern at this time because each individual living at LSSLC (411 individuals) communicated in some manner and as a result required the direct and/or indirect supports from a speech-language pathologist. The speech clinicians did not assign themselves caseloads organized by home, for example. They each completed assessments as they became due. Approximate caseload responsibilities were 137 individuals each for communication and the same 137 individuals each for oral motor/ mealtime. The CFY clinician would be able to assist with these responsibilities, but would require supervision throughout this next year before she would be eligible for licensure. Ultimately, this ratio would be reduced were she to become a full time employee, resulting in approximate caseloads of 103 each for communication and 103 for mealtime concerns for each of the four SLPS at that time. While improved, this would continue to be a significant workload for these clinicians, one of whom who would be a new graduate. <u>Supports are provided to individuals based on need and not staff availability</u>. As stated above, at the time of this on-site review, each of the three clinicians had a caseload of approximately 137 individuals in two critical service areas: communication and mealtime supports. Given this ratio, it would be extremely difficult to adequately meet the needs of the individuals at LSSLC. Basic supports would include at least an annual assessment or update, development of communication strategies for use by staff, communication dictionaries, dining plans, and the routine monitoring and revision required. This did not include those who would require direct speech-language services or more intensive supports necessary for using AAC systems, and/or attention to address increased risk for aspiration or choking during meals. Assessments appeared to be completed prior to the PSP, anywhere from two days to one month prior, but the report was not typed until only a day or two before the meeting, in some cases (Individual #497 and Individual #42).	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three	<u>All individuals have received a communication screening. If newly admitted, this occurred within 30 days of admission</u>. All individuals were reported to be provided a full assessment every three years with additional interim updates, per the statement	

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	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.	submitted in response to a request document request from the monitoring team, rather than screenings. A request for five current communication assessments from each clinician was also made by the monitoring team. Only seven updates were submitted for three clinicians. There were five submitted for Nancy Jo Flournoy, MS, CCC-SLP, two for Rhonda Hampton, MS, CCC-SLP, and none for Christi Hodges. Each of the documents submitted were identified as updates, that is, no current assessments identified as baseline or comprehensive were submitted. It was not determined if communication assessments for those individuals newly admitted were conducted within 30 days. This will be further evaluated in subsequent reviews by the monitoring team. All individuals identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills. As stated above, a request for the five most current communication assessments for each clinician was made by the monitoring team. A sample of only seven assessments was submitted; there were five documents submitted for Nancy Jo Flournoy, MS, CCC-SLP, two for Rhonda Hampton, MS, CCC-SLP, and none for Christi Hodges. They included the following: By Nancy Jo Flournoy, MS, CCC-SLP: • Individual #492 (03/02/10) • Individual #422 (03/03/10) • Individual #572 (01/27/10) • Individual #398 (12/22/09) • Individual #497 (01/29/10) By Rhonda Hampton, MS, CCC-SLP: • Individual #129 (02/26/10) • Individual #554 (02/09/10) In the sample of seven assessments reviewed, all were described as "updates" rather than comprehensive assessments, even for those who had received a three year assessment including: • Individual #422 (03/03/10), Individual #129 (02/26/10), Individual #398 (12/22/09), Individual #42 (03/02/10), and Individual #497 (01/29/10). They each received "updates" to the "Evaluation Update" conducted in 2007, three years ago. In the case of Individual #554 (02/09/10), she received an update to a Baseline Evaluation previously completed on 01/29/07. Individual #572 had received updates to his Baseline Evaluation, dated 01/24/07, on 12/13/08, 02/12/09, and, most recently, on	

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		01/27/10. It was unclear why these were updates rather than new comprehensive evaluations as per the plan described by the staff. The updates were generally thorough and there was some comparison to the individual's current communication skills to those previously reported. • In the case of Individual #572, his update indicated that he had received supports and updates since his Baseline Evaluation on 01/24/07. He was described as having had a communication book in previous years, though this had been discontinued in 2009 due to disuse. No alternative to the book was recommended or provided. For some reason, there was reference to changes in his performance on testing conducted in 2004, but no comparison to his performance in the Baseline Evaluation conducted in 2007. • Four individuals were described as using verbal communication (Individual #398, Individual #572, Individual #554, and Individual #497) with no recommendations for communication supports other than audiology for Individual #554 and Individual #497. • Three others were described as nonverbal or minimally verbal. Of these, only Individual #129 was recommended for communication services in the form of direct intervention to "determine needs for functional use of an augmentative communication system" and communication-related staff supports only for the other two (Individual #422 and Individual #42). Each of the updates was of a consistent format with a brief description of the audiological assessment. General information provided diagnosis and medical history as well as current communication status, sensory impairments, and behavioral considerations that impacted on communication. Communication history addressed methods of communication and previous interventions. Further test results and clinical observations were the basis for sections related to receptive and expressive language skills, articulation, voice, and fluency as indicated, though there was only a brief discussion of augmentative and alternative communication/assistive technology. Clinical impressions repeated most of the information already reported, but also provided a brief list of communication abilities. By report, there was an attempt to include speech and audiology in the evaluations and reviews conducted by OT and PT, but this was not always possible. The assessments for communication and audiology were addressed in one report, permitting good integration of that information. These reports were signed by both the SLP and the audiologist, Rosemary Simpson, AU.D., FAAA. It appeared that assessments were completed only per the PSP schedule rather than according to a prioritized need for AAC or other supports. There did not appear to be a concrete plan to guide communication assessment. No data	

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		base was submitted used to track completion of assessments and implementation of interventions identified. If receiving services, direct or indirect, the individual is provided a comprehensive Speech-Language assessment every 3 years, with annual interim updates or as indicated by a change in status. As stated above, only evaluation updates were completed, though during the staff interviews, it was reported that evaluations were completed every three years with updates in the interim. There was some reference to Baseline Assessments completed previously. Further assessment was reported to be conducted for those with a change in status, though there was no example of this noted in the small sample submitted. For persons receiving behavioral supports or interventions, the facility has a screening and assessment process designed to identify who would benefit from AAC. Note: This may be included in PBSP. Three of the seven individuals for whom assessments were submitted were reported to have positive behavior support plans to address self-injurious behaviors, inappropriate sexual behavior, disruptive behaviors, and physical aggression, for example. There was no evidence that the SLPs collaborated with psychology regarding interventions to address these concerns. Individuals determined via comprehensive assessment to not require direct or indirect Speech Language services receive subsequent comprehensive assessment as indicated by change in status or PST referral. Per the Staffing Summary dated 02/09/10, it was noted that Individual #128 had a communication board and participated in direct therapy two times monthly due to a decline in her communication skills. Though ruled out the year before, the clinician was again recommending that electronic communication training be reintroduced because she continued to show progress using the communication board in therapy. Communication-based supports and services provided were extremely limited and were provided to only a small percentage of the LSSLC census. Policy exists that outlines assessment schedule and staff responsibilities. The DADS policy dated 10/07/09 required review and revision of the "communication provisions of the PSP as needed, but at least annually." The Master Plan and Database were described to dictate the schedule of assessment based on need. Neither a plan nor database was submitted by LSSLC and, as stated above, the updates were completed for all individuals according to the PSP schedule rather than per a system of prioritized need. Findings of comprehensive assessment drive the need for further assessment in augmentative communication**.** Assessment related to AAC was included in the comprehensive assessment and update formats for all communication evaluations. This section was generally quite brief, sometimes only a couple of sentences.	

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		• Three of the individuals (Individual #398, Individual #497, and Individual #554), for whom updates were submitted, were determined not to require AAC due to functional verbal communication skills. • Individual #572 was described as "usually" understood by staff, but did not have interest in the use of a communication book or poster (01/27/10). It did not appear that exploration of these or other augmentative systems was going to be pursued. It was further recommended that he would be re-evaluated for this and possible "decline" in speech and language abilities in three years. • The update on 03/01/10 for Individual #42 was described as an "Update to the Evaluation Update" dated 02/07/07, nearly three years earlier. Per this most current update, it was determined by the clinician that "the development of an augmentative means of communication" was not indicated. She was deaf and blind with no reported responses to auditory or visual stimuli. Other sensory modes were explored, by report, with inconsistent responses noted. A trial of olfactory stimuli was recommended through training in her home and day program to enhance environmental awareness. There was no evidence that this would be directed, monitored, or reviewed by the SLP to determine if these activities were effective. Further there was no evidence that exploration of her response to other sensory modalities would be conducted, formally or informally. • The update for Individual #422, dated 03/03/10, was also described as an "Update to the Evaluation Update" on 02/27/07, three years earlier. His AAC assessment indicated that since he did not allow consistent hand-over-hand assistance for switch training, switch use for communication or environmental control was not recommended, despite his reported attempt to manipulate both pancake and joystick switches. It was of concern to the monitoring team that his potential for AAC use would not be further explored solely because he was uncomfortable with hand-over-hand assistance. The clinicians indicated that it was difficult to address everyone's needs due to the staffing limitations. • Per the PSP for Individual #323, he was seen for an update on 01/27/09 and 02/02/10. These were subsequent to a previous update on 01/23/07. By report, he had refused to participate in the evaluation on 01/27/09. It was of concern that the clinician did not attempt to conduct the evaluation at another time, but rather waited 12 months to follow up, at the time of the next PSP. He was observed to touch, reach for people and objects, turn his eyes and head toward sound, respond to his name, follow one-step directions, and point to named body parts. Nevertheless, in the AAC section of the report, it was stated, "Development of an augmentative/alternative communication device or environmental switch is not indicated as he shows very limited interest or responses to interact with his environment." Recommendations also included	

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		that Habilitation Therapies should be contacted if his "attention to pictures becomes more consistent" for re-evaluation of alternative communication. It was of concern that the clinician appeared to discount other types of AAC that did not require use or interest in pictures. By report, individuals were not generally observed in a variety of environments or with a variety of communication partners to thoroughly assess needs and potential for AAC use. Per the communication equipment database submitted, there were approximately 119 individuals listed with some type of equipment, though 27 of these were described as environmental switches rather than communication-based systems, and another 36 were earplugs. Other equipment listed included: communication books (16), communication boards (7), Chatter Vox (1), Dynavox (6), participation switches (11), community posters (3), and individual posters (2), in addition to audiology equipment such as hearing aids (5), listening devices (5), and earplugs (36). All audiology-related equipment had been issued per the database, but over 50% of the other devices (participation and environmental switches) were listed as recommended, but not issued as of 3/30/10. Some of these were listed as recommended well over one year earlier. The database listed recommendation dates for these unissued devices as follows: | | 2010 | 2009 | 2008 | | --- | --- | --- | --- | | Jan | 1 | 1 | | | Feb | 3 | | | | Mar | | 3 | | | Apr | | | | | May | | 1 | | | Jun | | 1 | | | Jul | | | 1 | | Aug | | 4 | | | Sep | | 1 | 1 | | Oct | | 4 | 5 | | Nov | | 2 | 5 | | Dec | | 1 | 1 | | Totals | 4 | 18 | 13 | Activity Plans existed for 19 individuals with Habilitation Therapies Programs in the area of communication skills, five of whom received direct supports for training to use a specific AAC system (Individual #378, Individual #248, Individual #128, Individual #300, and Individual #104).	

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		There were five others identified as having received direct communication supports, but these were discontinued based on a screening conducted in December 2009 and January 2010 (Individual #448, Individual #34, Individual #327, Individual #497, and Individual #27). Each of these individuals was then recommended for other communication opportunities, and service objectives were also identified for Individual #133 and Individual #27 with monitoring by speech staff.	
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.	Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP. In some cases, the communication updates were reported verbatim and in their entirety within the PSP. This did not appear to be a functional integration of communication into the process or delivery of supports but rather an exercise to be included in a document. In other cases, there was no evidence of a communication assessment in the PSP (Individual #111, Individual #308, Individual #213 and Individual #46). For example: • In Individual #46's PSP dated 12/16/09, it was stated that he spoke some words and sentences (page 5), but that he was also not able to communicate his desires verbally (page 9). There was no evidence that he had been assessed by a speech-language pathologist. • In Individual #213's PSP (01/27/10), there were very limited references to her communication abilities. One was under a section related to purchases, where it was stated that she did not communicate her desires verbally. The only other reference to her communication abilities was in the OT/PT Evaluation section of the PSP where it was stated that she communicated non-verbally, using vocalizations, facial expressions, natural body language, behaviors and manipulation of her environment. The Action Plan section of the PSP suggested that she had potential for functional skills such as pouring from a pitcher, wiping off a table, pointing to the medication cart, and placing coins in a purse, all skills that potentially could translate to the skills necessary to access AAC and the purposes of communication. She had target behaviors including physical aggression and hyperactivity, yet there was no evidence that the team considered her communication abilities or needs in the development of her BSP. The PSP contains information regarding how the individual communicates and strategies staff may utilize to enhance communication. As stated above, there were a number of cases in which the PSP did not identify an individual's communication abilities, needs, or methods for staff to use to enhance communication. AAC devices are portable and functional in a variety of settings. Approximately 16 individuals had been provided a communication book or individual poster. Another 27	

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		had only community posters. There were seven individuals listed with communication boards on their wheelchairs and another seven listed with higher tech devices such as a Dynavox. With the exception of the community posters, these systems were generally portable for those to whom they were provided (only 30 individuals); there were numerous others who had no device of any kind. As stated above, many of the participation and environmental switches recommended had not been issued. Because there was no database submitted by LSSLC, it was not known to the monitoring team how many individuals were non-verbal, but it was clear that there were more than these 30 who would likely benefit from AAC. Many of the systems recommended, but not issued were for environmental control with limited communication-based supports. These were generally activities for the individual to do alone and would not readily promote communicative interaction or social engagement with others unless strategies were built in for the individual to request the item, for example. Though it appeared that the intent of the device as prescribed by the clinicians was that they be portable and functional, the devices were not implemented throughout the day across settings and contexts. <u>AAC devices are meaningful to the individual</u>. Though only 30 individuals had AAC devices of some kind, they appeared to have the potential to be meaningful and functional. Per the Staffing Summary dated 03/10/10, Individual #378 had participated in direct diagnostic speech therapy from March 2009 to August 2009 and a Service Objective was initiated on 08/14/09 for participation in continued direct therapy for training to use a PECS (Picture Exchange Communication System). The summary recommended that direct service continue four times a month with a goal to shift from a pull-out setting to more integrated settings in his home and other environments. There was no evidence of a target date within which this was to occur. It was of concern that this communication method was restricted to the therapeutic setting after one full year with no specific plans for functional use in the context of this individual's daily life and routine. Environmental control in and of itself and to the exclusion of a system to communicate beyond simple yes/no responses, was not meaningful or functional. Ability without opportunity for participation results in meaningless, non-functional activity. Communication is engagement with others. Appropriate AAC must create those opportunities. <u>Staff are trained in the use of the AAC</u>. A 30-minute training by SLPs related to AAC was implemented in New Employee Orientation a couple of months ago, by report, though other staff training related to communication was not provided. This course was not	

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		competency-based and included a written test only. There were no plans for refresher courses for staff in the area of communication or AAC at the time of this review. No curriculum materials were submitted for this course. Activity Plans were submitted for approximately 19 individuals for home- or program-based communication supports, though it was not clear if or how staff were trained to implement these communication-based plans. Very limited instructions, such as "provide hand over hand assistance for pointing to pictures on the communication poster," were included, for example, in the Activity Plan, dated 03/03/10 for Individual #169. A "Communication Skills Therapist" was to review and report on her use of the device in the Annual Staffing Summary due 3/11. Documentation of monitoring of this plan was to occur monthly in the PNMP data log. Most of these plans had been implemented recently in 2010 and one in late 2009. <u>Communication strategies/devices are integrated into the PSP and PNMP</u>. Refer to previous discussion regarding sections of PSP related to communication above. <u>Communication strategies/devices are implemented and used</u>. As stated above, a number of individuals had devices and communication strategies described for use but there was limited evidence of functional use throughout the day. <u>General AAC devices are available in common areas</u>. A number of devices were available in common areas in several of the homes, including communication posters. They were not observed in use during the on-site visit.	
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	<u>Monitoring system is in place that tracks: a. the presence of the AAC; b. working condition of the AAC; c. the implementation of the device; and d. effectiveness of the device</u>. PNMP monitoring included a section related to the use, condition, and availability of communication devices and community posters. The Activity Plans stated that monitoring was to occur at least monthly. There were only approximately 20 monitoring sheets submitted, each had been completed in January or February 2010. Only four individuals monitored appeared to have a communication device. There were no monitoring sheets submitted for at least 14 other individuals who had Activity Plans for communication systems. There were additional inconsistencies noted in the documentation. • The device for Individual #190 on 02/24/10 was not available. The PNMP Coordinator reported that the communication book was supposed to be provided by the Speech Department, but had not been received at the time of the review. She was reported to also have a walker communication board and a	

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	communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Dynavox, but these were not mentioned by the monitor. In addition, there was no documentation that the concern for the missing book was reported to anyone. • Individual #117's device was reported as not available on 02/26/10, but there were no comments made by the PNMP Coordinator and there was no listing of this device in the Communication Skills Database. • Individual #128's communication devices were reported to be available on 02/26/10. She was listed with a wheelchair communication board only; the PNMP Coordinator reported that she used the Community Communication Poster. • It was reported that Individual #243 used the Community Communication Poster, though this device was not listed in the Communication Skills Database. This monitoring sheet form did not address effectiveness or function of the communication system and it appeared that this was only reviewed by the speech clinicians one time a year at the time of the annual review, as stated in the activity plans, unless the individual participated in direct intervention with the SLP. QE monitoring in the area of communication also was very limited and there were very few comments for those items identified as incomplete. The elements were based on the elements relating to the communication section of the Settlement Agreement. LSSLC's QE department's scoring was high compared to the findings of the monitoring team for the same elements. <u>Monitoring covers the use of the AAC during all aspects of the individual's daily life in and out of the home</u>. There was no clear consideration or schedule to ensure that each device was monitored across all aspects of the individual's day. <u>Validation checks are built into the monitoring process and conducted by the plan's author</u>. At the time of the on-site review, there was no evidence that validation checks were occurring at LSSLC to ensure ongoing consistency of findings between monitors and across time.	

Recommendations:

1. Aggressively recruit experienced speech clinician(s) to ensure all communication needs are appropriately met.
2. Consider the establishment of a system of caseloads and a method to prioritize comprehensive assessments for communication and AAC.

3. Provide continued opportunities for continuing education for SLPs in the area of AAC to ensure that they have the knowledge and skills to appropriately select AAC systems and to capitalize on individual communicative potentials particularly for those with less overt communicative intent. The monitoring team recognized that DADS provided opportunities for continuing education, however, as reported throughout the baseline reviews, there was not a hands-on component to these programs.

4. Ensure that AAC provided is functional and meaningful for individuals. The facility must establish that communication is a responsibility of all team members. The speech clinicians are responsible to conduct thorough and timely assessments and make recommendation of systems that should be most effective for each person, however, they are not available throughout the day and across settings, so implementation must be supported throughout the day in those settings that are meaningful for the individual. Staff education is key to creating an environment that supports communication. There appeared to be some issues related to which team members were responsible for general use devices and person-specific devices. It must be clarified that these are each the responsibility of all team members. It is not appropriate to wait for the individual to obtain mastery of a device prior to integrating it into the individual's routine.

5. SLPs should take an active role in the mat assessments currently completed by OT and PT. Look at all aspects: swallowing, respiration, vision, motor skills, and switch access sites, in a variety of positions.

6. SLPs were making a concerted effort to get devices out for general use, however, the necessary instructional support, training, mentoring, modeling, and monitoring were not happening. Many of the existing staff did not have even the very limited foundational knowledge presented in New Employee Orientation. Staff did not intuitively know how to do this and will require ongoing modeling, coaching, support, and follow-up to get it right. A couple of inservices will not get it done.

7. Implement more communication during mealtimes. Individuals can initiate requests, interact with peers, and make social comments.

8. Initiate more opportunities for group interaction in the day programs. Model communication and interaction methods and strategies for staff in those programs.

9. Ensure that plans, assessments, and other documentation are consistent with regard to communication devices and how they are used.

10. Collaborate with psychology to design communication and behavior support plans to ensure coordination and effective intervention strategies.

11. Ensure that the monitoring system is regularly scheduled across all homes and is communication-focused to determine if the interventions and strategies that are being used continue to be functional, meaningful, and appropriately implemented.

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 Personal Support Plans (PSPs) for: • Individual #552, Individual #282, Individual #503, Individual #541, Individual #191, Individual #511, Individual #339, Individual #426, Individual #354, Individual #203, Individual #321, Individual #90, Individual #587, Individual #424, Individual #180, Individual #57, Individual #480, Individual #54, Individual #557, Individual #41, Individual #49 o Individual Education Plan for: • Individual #99 o Positive Behavior Support Plans (PBSPs) for: • Individual #369, Individual #41, Individual #426, Individual #556, Individual #31, Individual #516, Individual #255, Individual #444, Individual #99, Individual #517, Individual #593, Individual #333, Individual #480, Individual #245, Individual #57, Individual #192, Individual #460, Individual #134, Individual #131, Individual #470, Individual #39, Individual #305, Individual #285, Individual #565, Individual #504 o Skill Acquisition Plans (SAPs) for: • Individual #503, Individual #541, Individual #191, Individual #511, Individual #282, Individual #466, Individual #75, Individual #339, Individual #460, Individual #122, Individual #219, Individual #158, Individual #292, Individual #258, Individual #42, Individual #422 o Three months of progress notes of SAPs for: • Individual #466, Individual #75, Individual #339, Individual #460, Individual #122 o Six months of progress notes of SAPs for: • Individual #503, Individual #541, Individual #191, Individual #511, Individual #282 o Functional Life Skills Assessments for: • Individual #503, Individual #541, Individual #191, Individual #511, Individual #282 <u>Interviews and Meetings Held</u>: o Luz Carver, QMRP Coordinator; and Tawnya Baker, QMRP administrative assistant o Lisa Curington, Director of Employment and Day Services o Gemma Lewis, QMRP assistant o Sheila Gibson, QMRP <u>Observations Conducted:</u> o Observations occurred in every day program and residence at LSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals

	including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training, etc.), and • Implementation of behavior support plans o Annual PSP meeting for: • Individual #99
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The skill acquisition programs at LSSLC contained some of the components necessary for learning and skill development. They did not, however, contain all of these components and the methodology was limited to training one step at a time, and using only least-to-most prompting. The skill acquisition programs would benefit from the use of additional training procedures, regular graphing of data, systematic preference assessments when necessary, and formal assessments of treatment integrity. Additionally, it was not clear from record review why specific skill acquisition programs were chosen. Replacement behaviors were included in PBSPs, however, training steps, or any training instructions for replacement behaviors, were absent. Programs specifying the acquisition of replacement behaviors need to contain all of the components necessary for learning and skill development. Additionally, progress on all skill acquisition behaviors (including replacement behaviors) needs to be monitored, and instructional procedures modified as needed, based on each individual's behavior. It was clear that the facility was involved in establishing active treatment. The actual measures of individual engagement collected by the monitoring team, however, indicated that improvement in individual engagement was needed in most settings. Although there was evidence of many community activities, only one individual was employed in the community at the time of the on-site tour and there was no evidence that training in the community was developed to address individuals' needs for service or preferences. There were a number of questions regarding the adequacy of the educational services received by individuals living at LSSLC who were entitled to an education based upon their age and needs.

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S1	Commencing within six months of	This provision incorporates a wide variety of aspects of programming at the facility	

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	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.	regarding skill acquisition, engagement in activities, and staff training. To monitor this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. <u>Skill Acquisition Programming</u> Skill acquisition plans at LSSLC consisted of: • Residential Skill Acquisition Plans (SAPs) that were written and monitored by QMRP (qualified mental retardation professionals) assistants. SAPs were implemented by direct care professionals, • Vocational objectives written and monitored by employment services personnel, • Medical desensitization programs written and monitored by the psychology department, and • Activity Plans, written, monitored, and implemented by specific rehabilitation professionals (e.g., physical therapists, speech language pathologists) and generally implemented by DCPs. The habilitation plans are discussed above in sections O and R of this report and, therefore, will not be discussed further here. Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures had just recently begun to be developed by the psychology department and, therefore, are not included in this baseline review. The monitoring team will be reviewing desensitization plans in subsequent tours to the facility. LSSLC included replacement behaviors in each PBSP. Replacement behaviors are important behaviors designed to replace, or take the place of, undesired behaviors. For example, • Individual #131's disruptive and aggressive behavior was hypothesized to be maintained by allowing her to avoid undesired activities. The replacement behavior for Individual #131 was to teach her to tell staff that she did not want to participate in a particular activity. • Similarly Individual #369's SIB was hypothesized to function as a behavior to attain staff attention (see K9). Subsequently, her replacement behavior included teaching Individual #369 to ring a hand bell to potentially replace the SIB as a way to attain staff attention. On the other hand some replacement behaviors appeared to be general and unrelated to the hypothesized function of the behavior. For example,	

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		• Individual #285's SIB and physical aggression was hypothesized to be an attention getting behavior. His replacement behavior, however, was clapping his hands with staff, participating in meaningful activities, and aiding in his personal living skills. • Individual #333's and Individual #192's replacement behaviors were identical: making choices within their environment. All replacement behaviors should be individualized, based on the results of the functional assessment, and represent behaviors that serve the same function as the undesired behavior. Finally, there were no descriptions of teaching conditions, no specific teaching instructions, and it was not clear how, or if, staff were trained to teach the replacement behaviors. It is important that DCPs are trained in the implementation of replacement behaviors. Further, these replacement behavior training procedures should be incorporated into the general SAP methodology, and conform to the standards of all skill acquisition programs listed below. An important component of an effective skill acquisition plan is that it is based on each individual's needs identified in the functional assessment or PBSP, psychiatric assessment, language and communication assessment, Personal Support Plan (PSP), or other habilitative assessments. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be meaningful to the individual and represent a documented need. The process for identifying specific SAPs at LSSLC for an individual began with the completion of the personal focus worksheet (PFW) and the completion of the Positive Adaptive Living Survey (PALS) or Functional Life Skills Assessment to identify adaptive and vocational needs. Interviews with QMRPs and QMRP assistants indicated that they did attempt to incorporate preferences and needs in the development of each individual's SAPs. The relationship between identified needs and individual preferences and the SAPs, however, was not apparent from reviewing each individual's PSP. For example one of Individual #422's needs was to develop money handling skills. One of his SAPs was that he will smile when the coin pouch is placed in his hand. It is not clear how smiling is related to the need to develop money handling skills. Skill acquisition plans should address needs identified in each individual's assessments. The PSP should clearly indicate the integration of these documents and their contents into the decision process of choosing skills to teach individuals at the facility. The overall goal of skill acquisition programming should be made clear to direct care staff implementing the plans, and others who might read the plan, that these plans were developed to promote growth, development, and independence.	

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		Once developed, skill acquisition plans need to contain some minimal critical 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: • well-written behavioral objectives that define behavior and training conditions, • operational definitions of target behaviors, including a task analysis when appropriate, • specific instructions, • relevant discriminative stimuli, • detailed and clear teaching instructions (e.g., shaping, prompting, fading of prompts), • specific consequences for correct and incorrect responses (including individualized use of positive reinforcement), • a plan for generalization and maintenance of the skill once mastered, • regular monitoring of results, and • modification or discontinuation of skill acquisition plans if objectives are met or if progress has stalled. The SAPs at LSSLC included many of these components. On the other hand, none of the SAPs reviewed included relevant discriminative stimuli or a plan for maintenance and generalization of achieved skills. Additionally, the training methodology for every SAP at LSSLC was identical. It included the training of one step of a task analysis, for example, turning on the water, for a goal of washing hands. When turning on the water was accomplished, then putting hands under the water was the next SAP. Additionally, all the SAPs reviewed also used least-to most prompting procedure. For example, Individual #122's SAP was to give money to a cashier to pay for items purchased. After the initial command, the trainer was to wait 5-10 seconds for a response. If he did not respond the trainer was to provide a verbal prompt by repeating the instruction. If individual #122 still didn't respond he was to be given a gestural cue (e.g., pointing). If he did not give his money to the cashier after the gestural cues, he was to be given a physical prompt (e.g., nudge his arm). If Individual #122 continued to be unresponsive, he would finally be physically guided to give the cashier the required amount of money. These training procedures can be very effective, however, they are not generally effective with <u>every</u> individual across <u>all</u> skills trained. In fact, the majority of individuals at LSSLC did not demonstrate clear progress. The following are typical examples: • Individual #503's six month progress notes indicated that he made progress on one SAP, no progress on three SAPs, and demonstrated a loss of skills in one SAP. • Individual #282's six month progress notes indicated that he progressed in two	

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		SAPs, demonstrated no progress in two other SAPs, and his skill declined in one SAP. • Six months of progress notes for Individual #511 showed progress in two SAPs, and no progress in five SAPs. • Six months of progress notes indicated no progress in any of Individual #541's or Individual #191's SAPs. These results demonstrated the need for LSSLC to expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires. These methods include total-task chaining (i.e., the learner receives training on each step in the task analysis during every session), backward training (i.e., all the steps in the task analysis are initially completed by the trainer, except for the final behavior in the chain), and shaping. Skill acquisition plans should be reviewed regularly and plans should be modified if goals have been achieved, or due to lack of progress. QMRP assistants summarized SAP data monthly and presented those data at quarterly meetings. The monitoring team noted several examples of SAP modifications following the quarterly meetings due to lack of progress or the achievement of goals. Nevertheless, as discussed above, several individual's SAPs had demonstrated a lack of progress, or regression, without a revision in the SAP. Additionally, the monitoring team noted examples of SAPs that were achieved, but the plans were not modified to include the next training step (e.g., Individual #282 achieved a hand washing goal on 10/12/09, but continued with training on that step). Additionally, the graphing of monthly SAP data would likely improve the ability of the QMRP assistants and team members to make more consistent data-based decisions concerning the continuation or modification of individual's SAPs. Another variable that would likely improve the overall effectiveness of SAPs at LSSLC is the inclusion of regularly assessed integrity data. That is, a direct measure that DCPs are implementing the SAPs as intended. The QMRP assistants report that they did attempt to observe DCPs implementing SAPs to ensure that they are conducted as written. The QMRP assistants, however, do not assess integrity in a systematic manner or on a specific schedule. It is recommended that a plan be developed to collect and graph data measuring the degree to which SAPs are conducted as written at LSSLC. <u>Engagement in Activities:</u> As a measure of the quality of individuals' lives at LSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and residences at the facility was	

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		measured by the monitoring team in multiple locations, and across days and time of 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 residence and day program are listed below. Overall, the average engagement level across the facility was 42%. As can be seen in the table below, there was considerable variability across settings. An engagement level of 75% is a typical target in a facility like LSSLC, indicating that the engagement of the individuals had considerable room to improve. It was apparent to the monitoring team that the DCPs were encouraged to involve the clients in active treatment. Like any new initiative, however, some DCPs were better encouraging active treatment than others. For example, the DCP in 557B was outstanding. She maintained the attention and participation of eight individuals for the entire 10 minutes of observation. On the other hand, other staff looked very uncomfortable attempting to engage individuals in active treatment, and the individuals responded by remaining uninspired and unengaged. The next step is for the facility is to work on individualizing the activities scheduled, provide additional staff training, initiate data collection, and actively manage individual engagement. Individualizing refers to ensuring that engaging activities are preferred, and are appropriate to the skill capabilities of the individual. Another one of the most direct ways to improve active treatment is to objectively monitor individual engagement by collecting data, and establishing specific engagement goals in each home and day program site. Of course, variability across sites is expected, based upon the type and number of individuals and staff in each setting. A specific, detailed, and reliable method for collecting engagement data will be required. The process should also include the reporting of data to managers and staff. <u>Engagement Observations</u>: Location / Engaged / Staff-to-individual ratio 559 A — 0/5 — 3:5 559 A — 0/8 — 2:8 559 A — 1/12 — 3:12 559 A — 1/12 — 2:12 559 B — 2/16 — 2:16	

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		557 A	3/7	2:7		
		557 A	4/5	1:5		
		557 B	0/4	1:4		
		557 B	2/4	2:4		
		557 B	8/8	1:8		
		557 B	0/3	1:3		
		549 D	0/6	1:6		
		549 A	1/7	2:7		
		549 A	3/6	1:6		
		549 B	1/11	1:11		
		549 B	5/5	3:5		
		565 Workshop	4/5	4:5		
		565 Workshop	7/9	2:9		
		565 Workshop	11/12	4:12		
		512 Arts and Crafts area	7/7	2:7		
		Seniors day program	2/7	3:7		
		565 Workshop	2/6	3:6		
		550 unit classroom	0/7	2:7		
		550 unit classroom	0/6	2:6		
		560 unit classroom	2/7	2:7		
		560 unit classroom	2/7	2:7		
		560 unit classroom	1/7	3:7		
		523	3/5	2:5		
		520 A	1/1	1:1		
		520 A	2/6	2:6		
		520 B	2/3	2:3		
		506	0/6	2:6		
		506	1/5	2:5		
		524	2/14	4/14		
		524	1/1	1/1		
		524	5/13	4:13		
		524	5/14	4:14		
		563 A	3/3	1:3		
		563 A	2/4	1:4		
		563 A	6/8	2:8		
		563 B	2/5	2:5		
		563 B	3/3	2:3		
		561 A	1/6	2:6		
		561 A	1/5	1:5		

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561 B	0/6	2:6
529	1/1	2:1

<u>Educational Programming</u>
Many individuals living at LSSLC were under age 22 and were entitled to educational services. These services were the responsibility of the local education authority, the Lufkin Independent School District (LISD). At the time of the on-site baseline tour, 34 individuals qualified for services from LISD. Many of these individuals attended all or part of their day in public school buildings away from the LSSLC campus. Nineteen students attended LISD schools for full school days and four attended for half days. The other students attended LISD schools for shorter periods of time. These students were picked up by LISD school buses and brought home at the end of their school session every day.

The LSSLC QMRP Director also served as the facility's liaison with LISD. She was assisted by the QMRP administrative assistant. During a meeting with the monitoring team, they described the relationship between LSSLC and LISD as being strong and collaborative. They described a past practice whereby LSSLC students attended an on-campus school program, but now were able to attend schools in town. They also described good communication with school principals and the school district, including for example informing LISD about attendance and transportation needs, and hearing from LISD regarding the status of each student.

The monitoring team was pleased to hear about the positive relationship between LSSLC and LISD and many positive outcomes. Examples included an adolescent who was receiving job training, and attendance by two of the students at the school prom. Nevertheless, the monitoring team had a number of concerns that are noted here and will be explored further during subsequent on-site tours.

First, during the PSP meeting for one student, Individual #99, the monitoring team learned that his educational program was provided on the LSSLC campus and not at an LISD school because of his behavior of running out of the building into possibly dangerous situations, such as into oncoming traffic. LISD told LSSLC that it could not keep him safe and, therefore, he could not come to school. Upon further investigation, it turned out that three students were not attending LISD programs. Instead, LISD sent a special education teacher to the LSSLC campus for three hours in the morning on each school day. The teacher worked with each of the three students separately for one hour each. It seemed highly unlikely that this one hour would meet this student's (and the other two students') educational needs. Other students attended LISD for part days due

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		to their behavior problems. It appeared that the decision to limit or prevent a student's attendance was made by the school principal. Second, school was scheduled to end on 5/28/10 and not start again until the end of 8/23/10, a 12 week break from educational services. Some, but not all of the students were to attend a summer program that was only half days and only for six weeks. The students at LSSLC appeared to need an extended year program due to their severe learning needs. This was especially true for Individual #99 (who was not scheduled to receive any summer program at all). Although LSSLC's QMRP said that the facility tried to incorporate some of his educational goals into his summer schedule, it should not be LSSLC's responsibility to do so, nor did it have appropriately qualified special educators to do so. Third, the IEP for Individual #99 was reviewed by the monitoring team. Individual #99's IEP did not look like it was designed specifically for him. For example, it contained annual goals for transformational geometry and United States history. These goals were certainly not correct for this student and were either included by mistake or as a requirement for all students. It also contained a goal for simple compliance to commands, compliance with classroom rules, and a reduction in behavior problems, including food stealing and touching and kissing others. Overall, this was a weak and inadequate set of goals for a student who was nonverbal, approaching adulthood, and in need of learning a variety of functional living skills. An appropriate IEP should include goals and objectives in all areas of educational learning for the individual student. The monitoring team wishes to support the positive relationship between LSSLC and LISD, however, the quality and appropriateness of the educational services received by LSSLC students needs to be looked at more closely. LSSLC and DADS need to assess and determine if these students are receiving the educational services to which they are entitled by state and federal law. This issue has been brought to the attention of DADS and it is expected that more actions will be taken regarding this area across all facilities where relevant.	
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.	As discussed above in S1, LSSLC conducted annual assessments of preference, strengths, skills, and needs. It was unclear, however, how the information from the Functional Life Skills Assessment or PALS was used in any systematic way to choose skills. Additionally, while the PSP and PFW attempted to identify preferences, no evidence of systematic preference and reinforcement assessments was found (see section K5 above for additional comments on the need for systematic preference assessments). Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	

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		The monitoring team noted that some discussion of barriers to community integration often occurred at PSP meetings and in the living options section of the PSP. This issue is discussed in more detail in the review of provisions F and T of this report, but also represents a source of information relevant to the choosing of skills that might be addressed for each individual using systematic instructional methodology.	
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	The monitoring team observed a staff conducting a SAP (i.e., table wiping) for Individual #192 in one of the day activity program rooms. Staff were able to articulate the SAP, the rationale for its use, the steps of the SAP, and the data collection procedure. Additionally, available data indicated that the plan was implemented according to the schedule specified in the SAP. None of the SAP data were graphed, however, and no direct measure of integrity of implementation of the plan was observed. The monitoring team believes that the graphing of individual SAP data would aid the QMRP assistants in data-based decision making. Additionally the inclusion of measures of integrity of implementation of plans would better ensure that SAPs were consistently implemented as written. Subsequent on-site visits will focus on the outcome of SAPs. That is, answering the question, are they producing meaningful behavior change?	
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the on-site tour, only one individual at LSSLC worked in the community. Thirteen other individuals were employed in the campus worker program that supported individuals working in campus jobs such as janitorial, kitchen help, or office work. The director of employment and day services indicated that the primary barrier to more community work was the lack of job coaches. Several new job coach positions, however, have recently been added and she was optimistic that more individuals would soon be employed in the community. The monitoring team will be looking to ensure that these community training opportunities address individual need and preference in future on-site tours. Many individuals at LSSLC enjoyed various recreational activities in the community. It	

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		was not clear, however, if these community activities were developed to address specific individuals' needs for services or preference. Subsequent tours to LSSLC will further evaluate the training individuals receive in the community.	

Recommendations:

1. Ensure that all replacement behaviors are individualized and based on the results of the functional assessment.
2. Ensure that all skill acquisition behaviors (including replacement behaviors) are based on needs/preferences documented in assessments.
3. Ensure that all skill acquisition plans (SAPs and replacement behaviors) contain the components necessary for learning and skill development.
4. Extend the training methodology of the SAPs to other procedures demonstrated to be effective in developing new behavioral repertoires.
5. SAP and replacement data should be graphed to aid in treatment decisions.
6. Develop a method to monitor if SAPs and replacement behavior trainings are implemented as they were written (treatment integrity).
7. SAP and replacement behavior data should be monitored monthly, and programs should be modified based on the effectiveness of the plans.
8. Develop a plan to address, monitor, and maintain reasonable levels of individual engagement in all settings.
9. Ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.
10. Ensure that individuals who are entitled to educational services receive those educational services, including, but not limited to, number of hours and weeks of schooling, appropriate individualized goals and objectives, and least restrictive environment.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and six attachments (exhibits) o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010 o LSSLC Policy, Initiation and Discontinuation of Services, Client Management-11, dated 7/17/08 o LSSLC Policy, Placement Appeals, Client Management-29, dated 4/1/08. o Community Placement Report, July 2009 through March 2010 • Individuals who have been recommended for community placement • Individuals who have been transferred to community settings o Community Placement Report, 7/1/09 through 2/28/10 • Individuals referred for community placement and any rescinding info (16 individuals) • Individuals placed in the community (five individuals) o Community Placement Obstacles, DADS statewide, FY10 through 1/31/10 o LSSLC Community Placement Obstacles through 5/28/10 o Position description: Admissions/Placement Coordinator o Position description: Post-move monitor o Post move monitoring schedule dated 4/17/10 o Admissions Inquiries and Referrals updates, 3/9/10 through 4/20/10 o Description of how LSSLC assesses an individual for placement o List of individuals assessed for placement since 7/1/09 o List of individuals who expressed an interest or wanted to be placed, but were not referred by their PSTs o List of trainings and educational opportunities for individuals, families, and LARs, July 2009 through March 2010 o Signature sheet of individuals and staff who attended MRA Provider Fair at Lufkin City Hall on 3/17/10, 37 individuals and 16 staff o List of individuals and staff who went on community tours through 3/30/10 o List of individuals who had a CLDP developed, July 2009 through March 2010 o Living Options Discussion Meeting Monitoring Checklists, blank forms and completed forms from 3/9/10 through 4/14/10 o PSPs for: • Individual #600, Individual #277, Individual #49, Individual #570, Individual #560, Individual #353, Individual #225, Individual #466,Individual #339, Individual #354, Individual #552, Individual #426, Individual #587, Individual #384, Individual #321 o CLDPs for:

	• Individual #384, Individual #564, Individual #600, Individual #277, Individual #49, Individual #54, Individual #508, Individual #180 o Post move monitoring checklists for: • Individual #384, Individual #564, Individual #600, Individual #277, Individual #49, Individual #54 o Post move monitoring checklists for individuals placed by another SSLC: • Individual #478, Individual #150, Individual #381 <u>Interviews and Meetings Held</u>: o Lisa Pounds Heath, Admissions and Placement Coordinator o Glenda Pierce, Post Move Monitor o Royce Garrett, Director, Individual and Family Relations o Gale Wasson, Facility Director o Precious Scott, MRA CLOIP Coordinator o Sheila Gibson, QMRP o Individual #158, Leader, Self-Advocacy Group o Group of QMRPs, including the Luz Carver, QMRP Director o Discussions and interactions with many other individuals o Parents of Individual #351 <u>Observations Conducted</u>: o PSP Meeting for: • Individual #99 o Community group home visit, post-move monitoring for • Individual #49 o All residences and day programs o Self-advocacy meeting
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Overall, LSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. Overall, however, very few individuals were in the referral process. An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various PSPs and documents at the facility. LSSLC had a number of staff who were dedicated to providing most integrated setting options to individuals. The newly appointed Admissions and Placement Coordinator, and Post Move Monitor are

	likely to help set the occasion for referral and placement to be more common at LSSLC. Overall, the process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual. Each PSP reviewed contained a living options discussion and most included some discussion of the type of supports that would be needed if the individual were to move. Most of the discussions, however, appeared to be brief an/or done in a rote manner. The CLOIP was implemented for every individual reviewed. As indicated, below, it should not be considered to be an assessment for placement and further work will need to be done to create an assessment for each individual. LSSLC conducted a number of educational activities and participated in regular meetings with local MRAs. The facility also had the opportunity to add to the content of the self-advocacy groups to include community placement, decision-making, and problem-solving as regular topics for discussion. Modifications were recommended for improvements to the post-move monitoring process.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of	LSSLC engaged in activities to encourage and assist individuals to move to the most integrated setting. These activities appeared to be consistent with the determinations of professionals that community placement was appropriate, and consistent with the individual's PSP (although see comments below regarding CLDPs and post-move monitoring). These activities were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the greater issues of state-provided services. Referral and placement activities were overseen by the Admissions and Placement Coordinator (APC). She was assisted by the newly hired post move monitor. Although both were newly appointed to their current positions, each these staff members had more than 20 years experience at LSSLC. Since 7/1/09, six individuals had moved to community placements as per the facility's process. Of these six, one had returned due to behavioral and psychiatric problems. In addition, three individuals were scheduled to move within the month or so following the onsite tour. The APC reported that PSTs were getting better at referring individuals, especially as they were learning about community providers and the potential benefits of placement	

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	the State, the resources available to the State, and the needs of others with developmental disabilities.	for many individuals. The APC maintained a document that was updated each week called the "Admission and Placement Weekly Report." The report was presented by the APC to the senior management team at their Tuesday meeting every week. At the meeting, she presented the contents of the document. This included: • requests for admissions from other SSLCs to LSSLC (five individuals were listed) • requests for admission from the community (nine individuals were listed) • status of each active referral from LSSLC to the community (17 individuals were listed, with details regarding the status of each of these 17) • transfer requests from LSSLC to other SSLCs (1 individual was listed) • on campus moves planned (no individuals were listed) • on campus moves requested (22 individuals were listed) • individuals who were referred by the PST for a community provider tour (29 individuals were listed) • a list of admissions since the beginning of fiscal year, 9/1/09 (nine individuals were listed) • a list of community tours that occurred since beginning of fiscal year (9/1/09) (33 individuals were listed) This document and report appeared helpful to the senior management team in understanding the status of referrals (as well as admissions and within-campus transfers) at the facility. Most impressive was the APC's intimate knowledge of each of the individuals on the placement referral list. A detailed look at the list, provided below, indicated that individuals were at various stages in the referral and placement process, from moving within the upcoming weeks, to recently referred. • Individual #180: CLDP meeting occurred, placement date was scheduled • Individual #142: provider was chosen, CLDP meeting was being scheduled • Individual #269: provider was chosen, CLDP meeting was being scheduled • Individual #77: provider was chosen, CLDP meeting was being scheduled • Individual #346: provider was chosen, provider was building a new home • Individual #278: provider was chosen, home being purchased by provider • Individual #449: was referred to a provider with experience with pica disorder • Individual #538: PST and parent working with a foster care agency to identify a specific placement • Individual #534: visiting providers, recently identified one that he may choose • Individual #294: visiting providers • Individual #398: visiting providers	

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		• Individual #565: visiting providers • Individual #418: rescinded, needed oral surgery, plan was to re-refer after recuperation in about six months • Individual #570: plan was to re-start the CLDP process so that the individual can participate • Individual #335: guardianship changed, plan was to reschedule CLDP meeting and re-do the CLDP • Individual #542: PST was rescheduling a meeting, no LAR in place, mother prefers LSSLC • Individual #350: referred by PST during past week The list of individuals changed each week as the status of the referral changed, discharges occurred, or new individuals were referred. For example, two other individuals were also in the referral process. • Individual #340: in process of visiting and choosing a provider • Individual #403: CLDP meeting was held in 3/10, scheduled to move the end of 4/10 Many individuals were interested and excited about the possibility of community transition. One individual spoke with the monitoring team about his upcoming move (Individual #340) and two others spoke with the monitoring team about their desire to move (Individual #484, Individual #106). LSSLC also maintained a listing of individuals who wanted to move, but were not referred. The listing included the reasons. Only nine individuals were on this list. Fortunately, only two were listed as being due to behavioral, psychiatric, or medical reasons; and only three were listed as being due to LAR choice (however, the monitoring team surmised that this last number was larger and that not all individuals were on this list). Three individuals were listed as not being referred because they were exploring community options. They were listed as such, not because this was an obstacle to placement, but because the PST wanted these individuals to have more time to explore possible options before a referral was made because once a referral was made, policy required placement to occur within the following 180 days. More detail on obstacles to placement is discussed below in section T1g. The referral process at LSSLC also respected the preferences of parents/LARs and the individuals themselves. The monitoring team had the opportunity to meet the parents of Individual #351. The parents described their high level of satisfaction with the services their daughter received. They told the monitoring team that they visited every month and that they liked her right where she was. She had been at LSSLC for more than 40	

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		years and they reported that they were very satisfied. This individual was not on the referral list. Similarly, the monitoring team had the opportunity to meet with Individual #158 at his home at LSSLC. He gave a tour of his home and talked about his daily and weekly schedule. He talked about what he would do if he had a problem and the types of jobs he had. He said that the residence was his home, that he liked living there, and that he did not want to move anywhere else. The January 2010 DADS Promoting Independence Advisory Committee report noted the number of Home- and Community-Based Services (HCS) slots that were appropriated by the legislature. There were more than 5,000 slots appropriated and additional new slots were to be made available specifically for individuals living at SSLCs. Overall, funding did not appear to be an obstacle to individual's transitions, however, one case required further examination. Individual #449 had a history of pica behavior (eating inedible objects) and a provider with expertise in supporting individuals with this behavior disorder was found. The monitoring team learned that the provider needed for the individual to be rated at a certain level of need in order to receive the amount of funding that the provider needed to provide services. The individual's level of need at LSSLC would not provide the amount of funding the provider needed. Subsequent to the week of the onsite monitoring tour, the monitoring team learned that the change in level of need rating was not approved and that the individual's referral had been rescinded. If funding was the sole reason for the rescinding of this referral, the PST and LSSLC management should have a mechanism for working with DADS to assess whether the reasons for change in level of need rating (and corresponding funding) were reasonable and, if so, ways that the placement process could move forward. Thus, two aspects of funding that the state should consider are (a) whether the funding determined by the individuals level of need at the facility will sufficiently fund the services needed in the community, and (b) whether success in the community will result in lower funding for a provider that in turn may result in fewer services to an individual. The monitoring team will examine these questions further on subsequent visits to LSSLC.	
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	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018.1 and was dated 3/31/10. This policy was updated from a previous version. The updates were relatively minor, primarily	

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	related to transition and discharge processes. Such policies, procedures, and practices shall require that:	regarding methods of reporting facility information to the state central office. The purpose of the policy was stated in the first paragraph and noted that it was to encourage and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included. The policy also detailed procedures for assisting individuals with movement to the most integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. LSSLC had adopted the state policy in full. LSSLC had received training in this new policy on 4/5/10. In addition, the facility had two other policies related to most integrated setting practices. The first was called "Initiation and Discontinuation of Services." It was in the policy and procedures manual labeled as Client Management-11, and was dated 7/17/08. The second was called "Placement Appeals." It was also in the policy and procedures manual labeled as Client Management-29, and was dated 4/1/08. Given that these two policies were created prior to dissemination of the DADS policy #018.1, and given that the contents of these two policies was similar, though not identical, to the DADS policy #018.1 the facility should (a) review these policies to ensure that they are not in disagreement with any of the contents of the DADS policy, (b) evaluate whether any of these policies could be eliminated because of the existence of the DADS policy #018.1, and (c) obtain some type of documentation of approval of these policies from the DADS central office discipline head. The monitoring team also looked to see if the policies and procedures were being	

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		implemented consistently. LSSLC staff were beginning to implement the DADS policy #018.1 and expected to eventually implement the policy in full. The Director of Admissions and Placement reported that they were part way through implementation and would continue to work towards full implementation, including addressing the quality assurance requirement in section T. The Admissions and Placement Coordinator was familiar with the new policy and its components. Further, the post-move monitoring position had recently been filled (on 3/1/10) and PSP documents and processes included many of the requirements of this new policy. Lisa Pounds Heath was the facility's Admissions and Placement Coordinator. She had more than 20 years experience in the DADS system and was very knowledgeable about the admissions, placement, and referral process. The monitoring team was impressed by her detailed knowledge of every individual on the referral list. For example, she knew the status of the referral and any complications regarding various aspects of the process for each individual. She was assisted by a post-move monitor, Glenda Pierce. Although new to this position, she also had more than 20 years experience at the facility. Both of these staff members were supervised by Royce Garrett, the facility's Individual and Family Relations Director. He had more than 30 years experience at the facility and supervised their work. This extensive experience will likely benefit the process of working towards each individual living and working in the most integrated setting based upon individual needs and preferences.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such	Fifteen PSPs were reviewed for the individuals listed in the Documents Reviewed list at the beginning of this section of the report. All of these individuals resided at LSSLC or had recently transitioned to community placements. The sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. <u>Protections, Services, and Supports</u> The PSP for each individual noted a variety of needs, required supports, and objectives for the individual while he or she lived at LSSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the Living Options Discussion Record (LODR) section of the PSP. The comprehensiveness of the discussion reported in the LODR varied across these PSPs. For example, in some cases, the report was multiple pages and included a lot of information about the individual's needs and preferences (e.g., Individual #277). In other cases, the LODR was missing (e.g., Individual #225) or was brief (e.g., Individual #600). All PSPs that contained an LODR included some indication of what the individual would	

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	obstacles.	need if a community placement were to be sought. Most of the LODRs referred to an "optimistic vision" or an "optimal vision" and included some individualized detail regarding the individual's preferences. This was good to see and indicated that the QMRPs had likely received some training in this area. The majority of the items were related to leisure preferences and safety. These are important aspects to consider when considering the most integrated setting for an individual, however, more in depth discussion was required. The living options discussion should include discussion about the ideal optimistic vision of the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, skill development and maintenance), and quality of life activities, such as leisure and recreation activities. Successfully facilitating this type of discussion will require additional specialized training of the person responsible. At LSSLC, each PSP meeting was facilitated by QMRPs. They had a variety of job responsibilities in addition to facilitating this discussion. The monitoring team had the opportunity to meet with all of the QMRPs. They described the living options discussion process and most, but not all, liked that this part of the PSP meeting now occurred at the beginning of the meeting. This was a recent change in process and is likely to help set the occasion for more thorough discussions. Previously, the living options discussion occurred towards the end of the meeting, often an hour or more after the meeting had begun. One QMRP stated that she was able to incorporate living options and supports throughout the remainder of the PSP meeting whenever it was appropriate to do so. The QMRPs were aware that the PSP format was going to be revised very soon and that they would be trained. They noted that DADS central office looked for their input. Overall, the group of QMRPs appeared to be experienced, knowledgeable, and desirous of having the PSP meeting be a meaningful experience for all involved. At the PSP meeting for Individual #99, the living options discussion occurred at the beginning of the meeting. The individual's parent participated via speakerphone. The meeting contained a detailed discussion about living options. He was under age 22, and the permanency planning process had been completed. The parent described the considerations both parents took into account when placing their son at LSSLC two years ago and how they had considered a group home option. The parent had spoken with the local MRA and was willing to consider placement in the community, but wasn't ready to do so yet. Members of the PST talked about the types of support Individual #99 would need. The parent said that he would had not ruled out placement and would consider it when Individual #99 was a little older. PST members then talked about the kinds of	

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		supports that can be available in a well-chosen community group home. Overall, this living options discussion was individualized and thorough. The remainder of the PSP meeting, and the planning for annual goals and objectives, however, showed much less individualization and led to a set of goals and objectives that were few, poorly chosen, and not likely to impact the individual in any meaningful way (this is discussed elsewhere in this report). At LSSLC, the Post-Move Monitor observed many of the PSP meetings and monitored the performance of the PST regarding the living options discussion. She had modified a DADS-generated checklist tool to do so. The tool looked at important aspects of the living options discussion. A review of the six most recently completed indicated that a lot of improvement was needed. LSSLC should take advantage of these data and this system of monitoring that was already in place. Overall, the comments indicated that improvement was needed in the PST's discussion of the individual's and LAR's awareness of community options and the types of supports and services that would be needed. She noted that the determination of most appropriate living arrangement was often hurried. One of the completed tools, however, indicated that the QMRP did a thorough job of presenting and developing the vision for an individual. Thus, LSSLC had some mechanisms in place to work towards improving the living options discussion at the annual PSP meetings. LSSLC was also in the process of developing a small home on campus to possibly serve as a transition home for individuals as a step towards moving into a community placement. This option could also be considered by PSTs during the PSP meeting, however, this type of option should not change the focus of the living options discussion, that is, to develop an optimistic ideal vision for the individual that includes all relevant protections, services, and supports. The monitoring team learned that DADS was developing new policies, practices, and training regarding Integrated Protections, Services, Treatments, and Supports (section F of the Settlement Agreement) and the person-directed planning process. The monitoring team looks forward to implementation of these revised practices. <u>Obstacles to Movement</u> There was no coordinated plan or approach to address obstacles to movement to the most integrated setting across the facility. In many of the PSPs reviewed, however, plans to address obstacles were included in the action steps section of the PSP. These were action plans labeled, for example, "to overcome the barriers to living in a less restrictive setting," or to "seek alternate placement." The specific actions to address the goal included, for example, to "continue to implement the PBSP," and to "tour group homes." This was an interesting mechanism to address obstacles, but will require oversight and	

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		direction from DADS central office and LSSLC senior management if this is to be LSSLC's method of meeting this requirement. This is required because there will need to be a way to ensure that the quality of this process is consistent for all individuals. This means that all obstacles must be addressed, the methodology must be appropriate and comprehensive, and the outcomes must be measureable and clear. Any plan to identify and overcome obstacles should include strategies that: • are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary. Planning and discussing possible most integrated settings and addressing obstacles to placement may improve when other areas of service provision improve, including, as noted elsewhere in this report, the overall integration of services.	
	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.	LSSLC was engaged in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in, or was planning to engage in, each of the five activities listed in the DADS policy. Some of this was described in a document listing training and educational opportunities for individuals, families, and LARs from July 2009 through March 2010. First, a provider fair was held in October 2009. Individuals, families, and LARs were invited to attend. Very few parents or LARs attended. Another provider fair was organized by the local MRA, the Burke Center, in March 2010. Again, few, if any, parents or LARs attended, however, 37 individuals and 16 staff went to the fair. It was held at the Lufkin City Hall. The provider fair (and visits to community providers) also may educate PST members and staff members about community providers. This may be helpful for future living option discussions. Second, a community living options inservice was scheduled for May 2010. This was expected to become an annual inservice. Third, a Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) was also in place for each individual. The process was intended to provide information to individuals and LARs. The MRA contracted for the CLOIP at LSSLC was the Burke Center. There were five full time MRA staff who were responsible for this process at LSSLC. The MRA staff attempted to educate each individual by establishing a relationship, doing interviews, showing pictures, and working with LSSLC to set up the visits to community providers. Letters	

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		were sent and phone calls were made to family members to discuss the process and community options. The CLOIP was to inform and educate. The monitoring team had the opportunity to talk with one of these MRA CLOIP staff members. She was very experienced and had responsibility for 88 individuals at LSSLC. She visited with each individual three or four times a year, including 45 days prior to the annual PSP meeting. She said that overall, LARs were satisfied with services at LSSLC. She described the local providers and that the MRA had a good working relationship with them. She noted that providers were wanting to grow their services in order to serve individuals who might be placed from LSSLC. Fourth, the facility took individuals on visits to community providers. These tours had only begun in March 2010 and more were expected to be conducted. At LSSLC, an individual must be referred for a tour by the PST. This may not be in line with the DADS policy item III.A.4 that states, "Each individual will be afforded the opportunity to participate in tours of community provider homes, day programs, and employment opportunities." At LSSLC, only those referred were offered an opportunity for a tour rather than everyone having an opportunity unless there was a reason for a tour to be denied, such as due to LAR preference. In addition, some type of summary data or tracking database was needed to determine if all individuals who were supposed to have these opportunities were indeed presented with these opportunities, the number of times each individual went on a visit, the goal and outcome of the visit for each individual, and whether the visit was in line with the information in the living options discussion section of the PSP. Fifth, a living options discussion was required to occur and this, as noted above in this report, was occurring at every annual PSP, however, more work was needed to have these discussions be more comprehensive and meaningful. Finally, although not solely related to education about community placements and providers, LSSLC had a number of active self-advocacy groups. The activities of the self-advocacy group can play a large role in educating members of the group, as well as the greater population of individuals at LSSLC, about community living options. The group will need guidance and direction from the facility's ombudsman in order to be successful. In summary, LSSLC was in the early stages of developing and implementing a plan to educate individuals and their families and guardians. Further work will be needed to meet the DADS policy on most integrated setting practices, section III, paragraphs 1-7. LARs and PST members must be knowledgeable and be assured that the community has	

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		the resources to support individuals in these individualized ways. Safety, medical care, independence, and socialization are of the most importance to most family members and LARs.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. Thus, during the on-site tour, the monitoring team attempted to find out how LSSLC assessed an individual for placement. There did not seem to be a simple description of how LSSLC assessed an individual for placement. The Director of Admissions and Placement stated that the process was the LOD and was done at PSP meeting. There was no tool used at LSSLC for this purpose. A document given to the monitoring team was meant to be a description of how LSSLC assessed an individual for placement. It noted that each individual would be assessed at least annually, that a living options discussion was completed, and it repeated, word for word, the DADS policy, section III.B, items 1 through 6. The facility and the state need to determine how individuals are to be assessed for placement. This will likely require the development of a tool for this purpose. The assessment would need to include the individual's needs, strengths, and preferences. It should include what is required to address the individual's needs, support his or her strengths, and meet his or her preferences. The context of the assessment should be the PST's vision of the components and characteristics of an ideal living setting for the individual. The assessment should draw on PST members and family members/LARs. As noted in this report, some aspects of this process existed at LSSLC, such as some of the components of the PSP process, the living options discussion, and parts of the CLDP. The Monitors have raised this with the parties and expect for there to be resolution in the near future. The CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences for placement. The CLOIP was in place for approximately three years and, as a result, documentation existed for all individuals reviewed for this report. MRA staff reported that there was not much change from year to year for most individuals. The MRA staff also tried to gather information from the family/LAR. Over the past year, this was done by telephone for all but one individual. Nevertheless, as noted above, the monitoring team expects the referral process and all of the activities related to this section of the Settlement Agreement to continue to develop.	

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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:		
	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 DADS policy on most integrated setting practices #018.1 provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. It also directed that a representative of the individual's PST to submit a current assessment and/or discharge summary for inclusion in the CLDP. Eight CLDPs were reviewed for the individuals listed under the "Documents Reviewed" list at the beginning of this section of the report. These represented 100% of the CLDPs developed at LSSLC since 7/1/09. At LSSLC, the APC was the lead person in developing and writing the CLDP. She gathered information to put into the CLDP from discharge summaries, PSP LOD, and anything discussed at CLDP meeting. Assessments from each discipline were updated for inclusion in the CLDP. The monitoring team was not able to observe a CLDP meeting because none were scheduled for the week of this on-site tour. The monitoring team requests that the facility work with the monitoring team to schedule a CLDP meeting at a time during the early part of the week of the next on-site tour.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs included indication that the APC and facility director had responsibility and had agreed to the contents of the CLDP. It did not, however, refer to any specific actions. Each CLDP also referred to a specific date for moving to the new placement and that staff would have the individual ready at that time. The CLDP essential and non-essential supports page listed specific actions that were required, but did not indicate whether any facility staff were responsible in any way. It did include the provider staff responsible and it did include timelines.	

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	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.	Signatures were found in only three of the eight CLDPs (these three were the CLDPs that were part of the original monitoring team document request). For these three CLDPs, signatures indicated that guardians or LARs (when any existed or were appointed) were informed of the CLDP and participated in the process. Signatures of individuals were on each of the CLDPs, too, indicating their participation. In the other five CLDPs, although there were no signatures, there was indication in the narrative sections that families, LARs, and the individuals were involved in the process. It was likely that the signature pages existed, but were not part of the CLDPs submitted to the monitoring team during the onsite tour because these CLDPs were printed from electronic files that did not contain the original signatures.	
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.	As per the DADS policy #018.1, current comprehensive assessments were provided to the receiving agency or provider as per report of the Admissions and Placement Coordinator. The documents for three of the individuals were reviewed in detail. Although numerous assessments were included, it was not possible for the monitoring team to determine if these assessments represented the full set of assessments relevant for the individual. The APC reported that she knew which assessments were required and that discharge summaries were also required for all disciplines (this was a new requirement). That is, even if an assessment had been done within the past year, an updated summary was required, too. The APC then listed these in section III.B of the CLDP. Although the APC was knowledgeable and knew the details of each individual's transition status, some sort of checklist or tracking tool should be used. This was discussed with the APC and will be reviewed during the next on-site tour.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall	A key part of the state process was the identification of essential and non-essential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Non-essential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all non-essential supports needed to be in place and addressed. Non-essential did not mean not needed. The MRA had responsibility for ensuring that all essential supports were in place prior to the day of the individual's move. This responsibility was to soon become the facility's. This is likely to be more beneficial for the individual and for the transition process because of the facility's extensive knowledge about the individual, and because the facility will continue to be responsible for the post move monitoring of these supports.	

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	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.	Each of the eight CLDPs had a table that listed out essential and non-essential supports, the person responsible for making sure the support was in place, and the target date for putting these supports in place. The table listed 10 areas of supports (e.g., residential, vocational, safety). These pages were similar across all CLDPs in their brevity and lack of detail. There were approximately 10 essential supports listed for each individual and a number of these referred to basic logical or bureaucratic processes (e.g., residential services provided, safe environment, transportation) or to vague, non-measurable activities (e.g., leisure and social activities). The non-essential supports were similarly similar across almost all of these CLDPs and included, for example, opportunities for interactions with appropriate peers, opportunities to participate in choice of activities, and attending religious services of choice. LSLLC must improve the individualization of the essential and non-essential supports section of the CLDPs. This is especially important because the essential and nonessential supports section of the CLDP provides the facility with its one chance to ensure that certain aspects of support will be provided to the individual. If an important support is left out this listing, the facility has no way of following up on it and requiring the provider to put the support in place. Therefore, this component of the CLDP is so very critical to the ongoing success of each individual's placement. A review of one individual's CLDP indicated that a lack of thoughtful consideration of essential and nonessential supports may have contributed to the failure of her placement, her return to LSSLC, and her referral for transfer to another facility within the DADS system. The individual (Individual #600) had a long history of challenging behaviors, co-occurring psychiatric disorders, and troubled relationships with others. Her CLDP essential and nonessential supports, surprisingly, did not include any items related to psychiatric support (e.g., counseling, medication management), the need for a PBSP, dealing with issues around her smoking habits, or her specific preferences for certain kinds of employment. Instead, there were general comments regarding providing residential services, having a "safe environment to guarantee her success," having telephone and cable in her room, and attending religious services of her choice. A more thoughtful transition plan should have been in place. In addition, the facility did not have a system in place to verify that the essential and non-essential supports identified in professional assessments were included in CLDPs, or at the individual's new home, before the individual's departure from the facility. As noted above, this was handled solely by the APC. Improvements to this portion of the CLDP process might include a more detailed listing of essential and non-essential supports during the living options discussion at the PSP meeting for those individuals who have been, or are likely to be, referred for placement.	

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		Moreover, as noted below in section T2, each essential and nonessential support should be written in a way that the post move monitor can determine, objectively, whether or not the support is in place. The CLDP process must be modified at LSSLC to: • ensure that all needs identified in the individual's current assessment are indicated as essential or non-essential supports. • define each of these essential and non-essential supports in more detail, and • specify the support in a manner that can be measured or verified.	
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.	There was no quality assurance process in place at LSSLC regarding this section T of the Settlement Agreement.	
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	LSSLC was not gathering and analyzing information related to identified obstacles to individuals' movement to more integrated settings. LSSLC did not have a facility-wide needs assessment related to the provision of community services to people with developmental disabilities and obstacles to such placements. The APC reported that data were being gathered on obstacles and DADS office was working on developing an assessment tool. These data were collected beginning in February 2010. LSSLC had, however, a listing of individuals of obstacles to placement only for those individuals who had expressed a preference for placement, but were <u>not</u> recommended for placement (i.e., this listing was not for all of the individuals at LSSLC). The obstacles listed were: - LAR choice 56% - MRA not present at meeting 31% - exploring community options 25% - behavioral or psychiatric reasons 24% The list only contained 16 individuals and the list looked like it needed some editing. The total percentages equaled more than 100% (but perhaps more than one reason was listed for some individuals), two individuals were listed twice, some of the individuals had already been placed or had been referred, and the category of exploring community	

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	resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	options did not appear to be what one would consider to be an obstacle to placement. Thus, this list was not very useful. Even so, of note was that individuals would have been referred if the MRA staff member had been in attendance. This would appear to be relatively easy for the facility to correct. As indicated in this provision item T1g, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles. Further, the listing of obstacles should also include those individuals who had not requested placement and were not referred (i.e., all individuals at LSSLC). There was no indication that DADS had taken any appropriate steps to overcome or reduce these identified obstacles.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not	LSSLC presented a document called, "Community Placement Report, July 2009 through March 2010." It listed individuals who had been transferred to community settings (five individuals). It also listed 16 individuals who were in the referral process. The five placements were: • In-home foster care with own family: two individuals • HCS group home: two individuals • ICFMR group home: one individual	

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	generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	LSSLC had recently initiated the post-move monitoring process, including the recent hiring of the post-move monitor. The post-move monitor was knowledgeable about many of the individuals, the local providers, and the CLOIP process. The post-move monitoring forms were initiated in November 2009 and were going through revisions at the time of the on-site tour. The facility is fortunate to have a post move monitor who is knowledgeable and extremely motivated to make the post move monitoring role as relevant and helpful as possible. She should have the opportunity to network with other post move monitors and with DADS central office to ensure support, exchange of ideas and best practices, and problem solving. The APC and the post-move monitor maintained a post-move monitoring schedule that listed each individual's name, the new provider, and the dates by which the three required post-move monitoring visits were required to be completed. The facility was monitoring the individuals from LSSLC plus an additional six individuals who were placed in the facility's catchment area from other State Supported Living Centers. The monitoring team was pleased to see that the post-move monitoring process was in place and it appeared that the monitoring visits were occurring as per the required deadlines. All post-move monitoring was done on-site at the individual's residence while he or she was at home. Completed post-move monitoring forms were reviewed for each of the individuals listed above in the "Documents Reviewed" list at the beginning of this section of the report as well as for the individuals from the other SSLCs who were being monitored by LSSLC. Overall, the completed forms listed the essential and non-essential supports directly from the CLDP (but as noted above, many important supports were never included on the list). An additional problem with the post-move monitoring process requires mention. That is, the manner in which the post-move monitor should determine the presence or absence	

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		of each essential and non-essential support needed to be specified. For example, the presence of the support was often determined based upon staff or individual report rather than on any type of documentation (e.g., 24 hour staff). Moreover, transportation may have been considered present if a van was at the home rather than a determination as to whether the individual had access to activities that required transportation or whether the van was available for individualized activities. The CLDP should be modified to include the type of evidence so that the post-move monitor knows how to assess its presence or absence.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of one of the individuals who had moved to the community within the previous few months. The 45-day had been already been completed, therefore, this was not an official post move monitoring visit. The monitoring team wishes to thank the post-move monitor and the community agency for making arrangements for this visit to occur. The purpose of this visit was to learn about the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and non-essential supports. The individual (Individual #49) had moved in less than two months prior to this visit. Two other individuals lived in the home. Each individual had a single bedroom. The home was single-story and simply furnished. It was located in a typical residential neighborhood. The individual was mostly nonverbal. Overall, the individual appeared happy and to be settling in nicely. All supports appeared to be in place, except for the construction of a fence in the backyard. This, however, wasn't specified in her CLDP. The CLDP instead had a broad statement "a safe environment to guarantee her success in her new surroundings." This was an example of a support that was poorly written, had no detail or definition, and could not be measured. The need for a fence was stated by staff and should be considered part of this essential support. The monitoring team looks forward to an improvement in the post-move monitoring process during the next on-site tour (e.g., improved lists of supports, specification of supports, specification of the manner in which the post-move monitor is to determine the presence or absence of a support).	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered	This provision item did not apply to any individuals at LSSLC.	

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	evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;	This provision item did not apply to any individuals at LSSLC.	

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	(f) individuals discharged pursuant to a court order vacating the commitment order.		

Recommendations:

1. Fully implement the new state policy on most integrated setting practices.

2. Ensure facility policies are in line with state policies, and obtain documentation from state office regarding the approval of state policies that add to, or supplement, state policies.

3. Ensure funding is not an obstacle for placement for the individual noted in section T1a above.

4. Review and modify how the living options discussion occurs at the PSP meeting regarding the optimistic vision for the individual's placement in the community. Continue with plan to move the discussion to the early part of the meeting.

5. Address the identified obstacles to individuals' movement:
    a. within the PSP meeting for each individual
    b. across the facility by conducting an assessment and by developing action steps from DADS.
    c. review and revise what is considered an obstacle (e.g., MRA attendance at meetings, and exploring community options did not appear to be obstacles, but were listed as such).

6. Individualize the list of needed protections, services, and supports for each individual.

7. Create an assessment for placement as required by the provision item.

8. Improve the way important essential and non-essential supports are included in the CLDP:
    a. Ensure all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
        i. define each support in observable and measureable terms.
        ii. define the manner in which the presence of each support will be verified.
    b. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.
    c. Thoroughly discuss all PST members' concerns about placement, and consider all possible barriers to successful placement.
    d. Ensure that all relevant assessments are included with the CLDP.
    e. Add a component to the CLDP process to ensure that the above four recommendations (a-d)occur, such as through actions of the QA department or senior management.

9. Develop a quality assurance process.

10. Utilize the data collected by the post move monitor regarding the living options discussion of the PSP meetings.

11. Continue to work on education of individuals and LARs regarding most integrated setting practices.
    a. Ensure that all individuals have the opportunity to go on tours unless there is a specific reason why this should not occur.
    b. Track the individuals who go on specific tours to ensure that the tour is an appropriate one given the needs of each individual.

12. In the self-advocacy meetings, include discussion regarding choices, decision-making, and problem-solving related to, at a minimum, rights and community placement.

13. Revise the post-move monitoring checklist to include detail regarding (a) how the presence or absence of supports was assessed, and (b) follow-up activities for both essential and non-essential supports.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy (draft): Consent-Guardianship #019, dated 1/15/10 o LSSLC Policy: Affirming and Protecting Rights, dated 10/31/08 o LSSLC Policy: Legally Adequate Consent/Authorization for Treatment dated 7/17/08 o LSSLC Policy: Guardianship, dated 3/1/01 o LSSLC Individual Rights Assessment o List of guardianship meetings and meeting agendas held in February 2010 o Correspondence with groups regarding the need for guardians o List individuals with new guardians since 7/09 o Referral for Guardian List 11/09 to 12/09 o Priority listing for adults without guardians 5/1/10 o List of individuals with guardians o DADS 2009 "Your Rights in a State Supported Living Center" Booklet Interviews and Meetings Held: o Interview with Royce Garrett, Director of Individual and Family Relations; and Guardianship Coordinator o Annual PST meetings for Individual #332 and Individual #524 Observations Conducted: o Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: A draft state policy addressing guardianship was developed in January 2010. In addition, the facility had a policy in place dated 3/1/01 that addressed assessing each individual for the need for guardianship and referring individuals for guardianship. It was not evident that the facility had been following its own policy in regards to seeking guardianship for individuals at the facility. According to facility documentation, a number of individuals were identified who needed guardianship, but only seven individuals had been appointed new guardians since July 2009. Thirty-seven individuals were rated a priority one (high need) for guardianship.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The state had developed a draft policy entitled, "Consent and Guardianship" (Policy #019 dated 1/15/10) to address this provision of the Settlement Agreement. LSSLC planned to adopt the state policy without revision. The draft state policy mandated that the facility appoint a Guardianship Coordinator who will maintain and update, semiannually, a list and prioritization of individuals who lacked both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The draft policy also mandated that the Guardianship Coordinator would create a guardianship committee to determine which individuals on the list had the greatest prioritized need based on factors listed in the policy. These factors for determining priority need were in line with requirements of the Settlement Agreement. LSSLC had made some initial attempts to address this provision of the Settlement Agreement. Specifically, the facility had assigned a Guardianship Coordinator and had begun to identify individuals who lacked both the functional capacity to render a decision and an appointed guardian. At the time of the onsite monitoring visit, 189 individuals had been identified and were assigned a priority level of one, two, or three. Priority rating was determined by the following factors: • Individuals with no correspondent (there were 14 individuals); • Individuals with $1000 in their Trust Fund accounts (there were 123 individuals); • Individuals determined high risk by the medical staff (there were 18 individuals); • Individuals receiving psychotropic medication (there were 126 individuals); • Individuals with a behavior support plan (there were 113 individuals); • Individuals not capable of communicating their desires and wishes (there were 160 individuals); and • Individuals with right restricted by the team (there were 23 individuals). At the annual PST meeting for Individual #557, there was lengthy discussion with his mother/LAR regarding pursuing guardianship. She acknowledged that the team had sent information to her regarding guardianship, but she had not taken any action towards applying for guardianship. During the discussion around community placement, she stated numerous times that she was opposed to him moving into the community. The QMRP reminded her that since she had not yet pursued guardianship, her opinion may not weigh as heavily in the decision regarding placement. She agreed to pursue guardianship and asked the team not to make any placement decisions until she had a chance to complete the guardianship process. The facility should continue to develop a list of individuals who need LARs and begin	

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		pursuing guardianship for those individuals according to assigned priority.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The draft state policy addressed efforts that should be made to obtain LARs for individuals when the PST has determined there is a need for a LAR. The facility held three meetings in February with local community groups to educate the community members on the need for guardians. Even so, little progress had been made in obtaining new guardians. The Guardianship Coordinator had made efforts to locate community members interested in pursuing guardianship for individuals. A letter had also been sent to parents and family members on 4/1/10 encouraging families to keep their guardianship current and to talk with the Facility's Individual and Family Relations office about the guardianship process. This provision will be further reviewed during upcoming monitoring visits.	

Recommendations:

1. Continue identifying individuals in need of an LAR and prioritize the individuals based on ability of each individual to make informed choices regarding their health and welfare.

2. Continue to develop a list of LAR providers in the area.

3. Provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.

4. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.

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 LSSLS Policy: Management of Protected Health Information, Facility Operational Procedures Manual-Administrative-03, dated March 2009 o Active records of various individuals on the residences or pulled for review by the monitoring team. Interviews and Meetings Held: o The three unified records coordinators: • Rita Inman • Sheila Thacker • Stormy Tullos Observations Conducted: o Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: LSSLC had made some initial steps to prepare for implementing the new state policy on record keeping practices. The facility was waiting for more guidance from DADS regarding implementation of a new record order, including a new table of contents and guidance on how to create the new records. The position of Director of Records was vacant. The facility was engaged in a search for a qualified person to fill this role. The unified records coordinators were experienced at the facility, knew a lot about the current records system, and appeared eager to begin this new project.

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V1	Commencing within six months of the Effective Date hereof and with	DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1 and was dated 3/5/10. It was slightly updated from a previous version	

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	full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	in order to more thoroughly define each of the components of the unified record for each individual. LSSLC had its own policy, called "Management of Protected Health Information." It was labeled Administrative-03 and was dated March 2009. LSSLC should review this policy so that it is in line with the new state policy. If the facility management decides to maintain an additional policy, approval from state central office should be obtained. The monitoring team looked to see if LSSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement Agreement. At the time of the on-site tour, LSSLC had not implemented and addressed this provision. Thus, the current records did not meet all of the criteria listed in Appendix D. An extensive review of the records was not conducted during this on-site tour because the records were going to be revised and reorganized. The facility, as noted above, had taken some steps to prepare for meeting this provision. First, they recently assigned three unified records coordinators who will have responsibility for overseeing the new systems, including conducting the review of records as required in section V.3. They will work under the direction of the facility's director of the records department (when hired; the position was vacant during the time of the on-site tour) who will report directly to the Director of Quality Enhancement. The unified records coordinators had attended a statewide training in Austin in March 2010 and learned about the new records systems and ways in which they could provide support to facility staff by making the records as user-friendly as possible. LSSLC was fortunate to have experienced staff as their unified records coordinators. Their experience at LSSLC ranged from 13 to 28 years each and included many years in the role as file clerk at the residences. Their current duties were broad and included filing of documents in each individual's master record, providing census reports, responding to Advocacy Inc. requests for records, auditing active records, providing various departments with documents as requested (e.g., social work, medical), completing guardianship-related paperwork, and sending out letters for PSP meetings. They entered a lot of information into their database systems (e.g., something called Codelink), and prepared excess overflow documents for storage at an Iron Mountain facility. The results of audits of active records were kept by the unified records coordinators. That is, the information was not sent to the facility's QE department. This was another example of a lack of a coordinated QE program as LSSLC (see section E above). The unified records coordinators gave feedback to the home file clerks based upon their audits. This feedback was done informally, via email or a phone call.	

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		File clerks continued to be assigned to each of the five units. The unified records coordinators were to have responsibility for setting up all of the record components and the file clerks were to have responsibility for maintaining them. The file clerks reported directly to the unit directors. The facility will need to ensure that good communication and accountability are in place considering that more than one LSSLC department will have responsibility for meeting this Settlement Agreement provision. It appeared that the individual notebook will contain some original documents (e.g., data sheets, daily observation notes from direct care staff) that will only be removed and filed at the end of each month. The facility needs to consider, and plan for, the possibility of loss of an individual notebook or the disappearance of data or observation notes. This might be especially problematic if important data or critical observation notes were to go missing, especially if, for example, an investigation of an allegation of abuse was being conducted.	
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.	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate	A quality assurance and quality enhancement procedure to ensure a unified record was not in place. The unified records coordinators had copies of the monitoring team's checklist tool and were planning to adapt it for their own monitoring. In addition, LSSLC's quality enhancement department should be involved in addressing this provision item.	

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	corrective action is taken to limit possible reoccurrence.		
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.	This provision item cannot be addressed until the records are organized under the new updated format and the new policy is fully implemented, including section IV of the policy.	

Recommendations:

1. Implement the new policy, including, but not limited to:
   - modify records following new record guidelines order (table of contents)
   - develop and implement quality assurance and quality enhancement process
   - ensure records are used in making care, medical treatment, and training decisions.

2. Modify facility policy to be in line with state policy. Obtain approval for facility policy from DADS central office.

3. Incorporate record keeping quality enhancement activities into the facility's overall QE plan.

4. Ensure good communication between unit directors and their file clerks with the unified records coordinators and the Director of Quality Enhancement because both departments will have shared responsibilities in meeting this provision of the Settlement Agreement.

5. Review and consider the comments made above regarding aspects of the proposed new record keeping practices at LSSLC, including, but not limited to, safeguards for the possible loss of the contents of an individual notebook.

Health Care Guidelines

* Below, additional information is provided regarding some of the health care guidelines.

SECTION I: Documentation		
		Steps Taken to Assess Compliance: o Review of records, attendance at clinics, and interviews of all physicians as noted in Section J, L, and N.
		Summary of Monitor's Assessment: Documentation and integration of laboratory and x-ray findings into the integrated progress note was not meeting the requirements of the Health Care Guidelines. Overall, the progress notes were generally in a SOAP format, however, handwriting was difficult to read by some of the providers. Psychiatry dictated their notes, but the transcription process took up to 120 days. This made it difficult to follow the thinking and planning of the psychiatrist. The psychiatric providers were quite frustrated that when they were at a quarterly review, their previous dictation was not in the record for their own reference. The goal of having proper documentation should lead the facility to develop a system that any physician could use to look at the record, note the problems, and determine what the attending physician was thinking, any positive results, and be able to correlate it to the treatment plan. There was not a flow in the record that would allow for this process at the time of the onsite baseline review.
#	Item Summary	Assessment
I1a	Documentation: active problem lists (4 items)	Most individuals had an active problem list, however, the active problem list often did not include the most recent active problems. In the case of individual #203, the problem of hyperglycemia listed in the most recent annual medical summary, and treated with medication (Metformin), was not listed on the active problem list.
I1b	Documentation: acute medical problems (7 items)	The provisions outlined in this section were not fulfilled by the current documentation seen in the records reviewed. • Individual #532 had a recurring pelvic mass on ultrasound. The individual was given adequate care, however, the elements required for documentation were not present, including pertinent negative findings and reports of staff regarding symptoms. Notes were in the SOAP format, but were quite brief. • Individual #31 had a CT scan of the head ordered after injury that apparently was changed, but there was no rationale in the notes as to why this was changed. A skull series result, however, was noted in the record on 12/16/09, instead of the CT scan. • Individual #90 was noted by primary care to need "weekly follow up by psychiatry." Psychiatry ordered a change in medication on 12/31/09, consent was obtained on 1/5/10, and on 2/4/10 psychiatry noted the individual needed psychiatric hospitalization, however, the individual was not seen weekly and there was no note as to why the primary care physician's request was not honored. • Individual #9 had a note after treatment for acute iritis to be seen in four months, however, there was no follow up noted in the record.
I1c	Addressing chronic problems (3	None of the records reviewed demonstrated that ALL active problems were addressed on a quarterly basis

	items)	at the onsite baseline visit. Some active problems were not noted on the problem list, such as Individual #203 who was on Metformin for hyperglycemia, which was not on the active problem list. Individual #31 has known hypercholesterolemia, but no lipid panel had been drawn over the past year.
I1d	Documentation: integrated progress notes (7 items)	Lab reports were frequently signed by the physician reviewer, but not dated to note when the physician reviewed the result. There were rare progress note entries regarding the lab report reviews, and notations about the plan for the positive results were the exception rather than the rule. Examples from the record review were Individual #119 (FBS and HGBA1c), Individual #367(decreased ANC, no clinical integration), Individual #31 (elevated prolactin but no note about Paroxetine as a problem and no plan to change it), and decreased TSH from 9/09 to 4/10 in Individual #321, and the rationale for Levothyroxine was unclear from the progress notes. Positive findings on EKG reports were not explained in the progress notes (see section L above).
I1e	PCP orders (4 items, including Appendix A)	In the records reviewed, this appeared to be occurring partially. The areas, which were not attended to included the functional assessment with tentative plans to address each area, and the active problem list with outcomes specific to each area. Some of the problems may be addressed with specific outcomes but not in others. Examples were seen for Individual #203, Individual #532, and Individual #344.
I1f	Documentation: consultations (2 items)	Requests for consultation were often noted as an order to consult neurology next clinic. Neurology noted "watch for toxicity of Phenytoin" in a consult on 9/30/09, and despite the warning, including an elevated level in early October (26.9), Individual #423 required hospitalization for Phenytoin toxicity on 10/14/09.
I1g	Hospitalizations, transfers, readmits (8 items)	The facility appeared to have a plan in place to communicate to the facility upon hospitalization of an individual. When the individual returned, he or she was retained in the infirmary for 24 to 48 hours depending upon the needs of the individual and the evaluation of the primary care physician. The facility sent a nurse to follow up with every individual in the hospital and to enter notes in the record on daily progress. This item was partially addressed; the full summary of the hospitalization by the PCP in the integrated progress notes was lacking at the time of the onsite baseline visit in the records reviewed. The records were sent from the hospital at some point after the hospitalization and were included in the record.
I1h	Annual plan of care (4 items)	This was partially in place. Individual #180 did not have a current annual physical exam in the record. The medical director's individuals had the most comprehensive annual summaries, but as noted in section L, this area needed attention by all primary care physicians. Individual #488 and Individual #31 did not have an annual medical review in the record.

Recommendations:

1. Adoption of an EMR by LSSLC will certainly help to prompt integration of the positive findings on x-ray and lab into the progress note. It will also help with integration of outside results and consultations if it has the capability to communicate with the outside laboratory and radiology.
2. The physicians need to develop a standard for progress notes that include discussion of positive lab findings and their clinical correlation.
3. Immediate attendance to abnormal findings on EKG with clinical correlation noted in progress notes or annual summaries is needed.
4. If a procedure is cancelled, or the ordering physician decides upon a substitute procedure, a notation in the record (preferably the progress note) should include justification for the change.
5. Update the active problem list.
6. Review all active problems on a quarterly basis by primary care in the progress notes.

SECTION II: Seizure Management		
		Steps Taken to Assess Compliance: o Records reviewed as listed in sections J, L, and N. o Additional neurology records- neurology consults, medication orders, seizure graphs, previous six months of labs, MOSES scales for the following individuals: • #521, #144, #513, and #210.
		Summary of Monitor's Assessment: The population of individuals in treatment for seizure disorders at LSSLC included a number of individuals whose seizures were very difficult to control, including Individual #521, Individual 144, and Individual #569. Overall, there appeared to be access to neurology and in the onsite interview, the medical director stated that he has adequate access. The individuals appeared to be sent out of the facility for clinic or seen in the monthly neurology clinic. A major problem in reviewing the records was that some of the information might be in the neurologist's office and not in the individual's record. There were no EEG results noted in any of the records reviewed. There were often no references to results. Overall, it was difficult to determine when the most recent EEG had been done on the individual.
#	Item Summary	Assessment
II1a	Documentation of seizure freq., dur., characteristics	The seizure logs were the primary method for documentation of seizures. They were inconsistently filled out with some missing duration of the seizure; others were missing descriptions of the seizures. This was also true of seizure notations in the progress notes within the record. Individual #367, and #569 had poorly documented seizures in the records that were reviewed. In addition to seizure logs, seizure graphs were noted in the neurology specific records. This was simply a chart of frequency without characteristics. The neurology consultations noted that the staff reported on the characteristics of the seizure at the appointment.
II1b	Evaluation of initial or change in seizure pattern	Individual #367 was noted to have an increase in frequency of seizures in the first quarter of 2010, but there was no neurology consult within the last year in the record.
II1c	Neurologist is involved	Most of the individuals selected for review did not have a neurology consult within the last year. Individual #9 had an order written for rescheduling for neurology clinic in January 2010, however, no neurology visit or consult was noted in the record subsequent to the request. Individual #532 also had an order written on 7/09 to return to neurology clinic; it was re-written (he had not been seen) on 12/1/09 and there was no neurology consult noted in the record as of April 2010.
II1d	See neurologist at least 1x year if poorly controlled	Individual #367 appeared poorly controlled with an increase in frequency of seizures, but was not seen within the last year. Individual #119's PSP annual summary indicated that he was seen on 5/13/09 and 6/9/09 by neurology, but there was no consult or clinic report in the record for either date. The monitoring team was concerned that the individuals may have been seen, but there is no note in the record.
II1e	See neurologist at 1x every 2 years if controlled	This was being partial met at the time of the baseline visit. Individual #90 went three years between visits. Individual #9 was monitored for seizures by primary care, but there was no note indicating the most recent neurology consult.
II1f	PCP and pharmacist evaluate medical regimen	At the time of the baseline review this did not appear to be a collaborative effort.

II1g	Monotherapy is preferred mode of treatment	Neurology discussed the use of polypharmacy in their consults and was aware that the individuals in the facility were sensitive to sedative side effects and appeared to attempt to weigh the risks and benefits with family and the primary care provider within LSSLC.
II1h	Rationale provided if more than 1 anticonvulsant used	This provision was adhered to by neurology, but primary care was not consistent with this. The polypharmacy review tool would provide an excellent tool for commenting on the necessity of more than anticonvulsants.
II1i	Consideration of other treatments if not controlled	Neurology appeared to make use of VNS as an alternative to medication-only regimens. Individual #569 and Individual #144 were recipients of this treatment.
II1j	Medication is consistent with type of seizure	Not all seizures were classified, but those that were classified appeared to receive the correct medication.
II1k	Seizure classification follows Epilepsy Fdn.	Individual #488, Individual #106, Individual #344, Individual #180, Individual #90, Individual #532, Individual #9, and Individual #488 did not have classified seizures per this provision of the health care guideline.
II1l	Blood levels at six months	The levels were not always obtained at six-month intervals. The most recent VPA level for individual #321 was 9/10/09. Individual #180 did not have an oxcarbazepine level in the record. Additionally, the results were not always acted upon. An example was Individual #488, where the orders noted the oxcarbazepine level was toxic on 9/21/09, but the level was not in the record and there was no follow-up noted. Individual #423 became toxic on phenytoin requiring hospitalizations despite warning from neurology, and the existence of more than one elevated phenytoin level coupled with increasing ammonia levels (suggesting need for adjustment).
II1m	Blood tests for medication side effects at six months	This was being partially followed. Regular pharmacy input, along with a lab matrix will help the facility bring this into regular occurrence. Tegretol levels were requested (after an increase in dosage on 2/25/10) by the attending physician on Individual #113 on 3/22/10 and 4/11/10, and it was not available for review by 4/16/10.
II1n	More frequent blood levels for new meds	This was in partial occurrence at the time of the baseline visit. Individual #90 was missing CMP and CBC with platelets despite being on Tegretol.
II1o	Diagnostic and treatment regimen in PSP	This was not always present in the sample reviewed. Individual #488 has no medical portion. The PSP contained the diagnosis and treatment of seizures in the medical summary section. The problem of annual medical summaries was been discussed in section L of this report.
II1p	Cluster seizures identified and treated	LSSLC treated cluster seizures with Diastat and the medical director was content with the results of this treatment. With the use of the infirmary, these individuals were able to remain in the facility for treatment rather than to be repeatedly sent to an outside emergency room.
II1q	Status epilepticus defined	The medical director was clear about this definition and the physicians at LSSLC sent these individuals out to a local ER for treatment and/or further neurological work-up.
II1r	Status epilepticus treated as emergency	Individual #521 was sent to the ER after an episode of status epilepticus. She was briefly hospitalized for treatment of this episode with notes from neurology that her mother would rather her have seizures than be sedated with medication.
II1s	Weaning of medications if 5 years seizure free	There were no individuals selected for review that met these criteria at the baseline review.
II1t	Medication reductions done slowly and monitored	As indicated by review of the neurology consults, the neurologist outlined the taper schedule for the primary care physician.

II1u	If side effects impact life, PST will consider rationale	Individual #210 was sent to neurology for reduction of Phenobarbital secondary to cognitive impairment issues by the PST. Therefore, at least one of the sample reviewed met the guidelines. Further review is necessary to see if this can be generalized to the entire population of LSSLC.

Recommendations:

1. The individuals who are treated for seizure disorder need to have better access to neurology and the facility needs to arrange for such access either by increasing the frequency of neurology clinics onsite or offsite. It did not appear that all appropriate individuals had seen a neurologist within the past year or two. The monitoring team had questions as to whether or not all neurology visits were captured in the records.
2. There needs to be better communication in the record about the classification of the seizures as well as the treatment plan.
3. An accurate lab matrix for follow-up of appropriate monitoring of potential side effects as well as blood levels of each medication needs to be followed per the guidelines. Each lab result needs to be carefully tracked and clinically correlated to avoid toxicity. The facility needs to develop a procedure to ensure that the physicians are correlating the results with the individual.
4. The Pharm.D. can be instrumental in flagging potentially toxic results and reporting it to the physician for attention.
5. When orders are given for levels, the nurse case manager should be certain they are drawn and reported in a timely fashion.

SECTION III: Psychotropics/Positive Behavior Support		
		Steps Taken to Assess Compliance: o Records reviewed as listed in sections J, L, and N. o Interview of all psychiatric providers and primary care physicians.
		Summary of Monitor's Assessment: Implementation of the healthcare guidelines was in development at the time of the onsite baseline review. None of the areas reviewed were in full operation. Part of the problem in this arena was that providers were not fully aware of the standards in the guidelines at the time of the onsite baseline visit. Development of a lab matrix with expectations of the monitoring for each medication would be helpful to all of the providers. Providers were confused as to who might be monitoring which medication in the case of anti-epileptics.
#	Item Summary	Assessment
III1a	Initial psychiatric eval contents (7 items)	This item was missing in all records reviewed for the baseline visit.
III1b	General monitoring documentation (3 items)	Since January 2010, documentation had improved with dictation into the quarterly review of lab, behavioral targets, medications, and DISCUS and MOSES scales in the records reviewed since that time period. There were no monthly reviews on any of the individuals reviewed at the onsite baseline visit. Psychiatry did not seem to be aware of the specifics of the healthcare guidelines in this area.
III1c	Monitoring for anti-epileptics used for psych	Psychiatry admitted this was an area of weakness in the system because they were frequently uncertain as to who "owned" the antiepileptic medication. Since the three psychiatric providers were relatively new to LSSLC, most of the medications were in place prior to their joining the staff. In the case of Individual #569, the psychiatrist was uncertain as to whether the 6.0 mg of Clonazepam was being monitored by psychiatry or neurology.
III1d	Monitoring for lithium	Individual #54 was an example of problems with implementation in this area. There was no CBC, CMP or UA in the record over the past year. There was also no EKG in the record. Also Individual #90 was missing a CBC, UA, and CMP every six months as well. She ended up becoming lithium toxic (as a result of a medication error) requiring hospitalization in 2/10. These are the only two individuals on lithium in the sample of records reviewed and neither was being monitored in accordance with the guidelines.
III1e	Monitoring for tri-cyc anti-depressants and trazadone	Individual #344 was the only individual in the sample on Trazodone in the sample of records reviewed. The most recent EKG was from 8/08, therefore, this did not appear to be in agreement with the guidelines.
III1f	Monitoring for beta blockers when used for psych	There were no individuals in the sample reviewed on this regimen at the onsite baseline visit.
III1g	Monitoring for antipsychotics (6 items)	The healthcare guidelines did not specify monitoring that was considered standard of care for second generation (atypical) antipsychotics. This included waist circumference, weights, fasting blood sugar, HgbA1c, and lipids. As a result, some of the individuals were not receiving current standard of care monitoring for these medications. An example from the reviews included Individual #344 and Individual #54, neither of whom had lipid monitoring within the year. Individual #480 was missing both a CBC and CMP every six months.

Recommendations:

1. An up to date standard of care set of guidelines for monitoring atypical or second-generation antipsychotic medications needs to be an integral part of the lab matrix. This includes fasting blood sugars, weights, and waist circumference, HgbA1c, and lipids as outlined in the current APA guidelines.
2. All providers need to be made aware of the need for therapeutic monitoring and to be familiar with the lab matrix as it is developed for this monitoring. Audit trails will need to ensure compliance with the lab matrix.
3. Psychiatry needs to be held accountable for monitoring prolactin levels on offending agents such as Risperadol and Paroxetine. Alternative and less offending agents should be chosen if possible so as not to aggravate osteopenia or osteoporosis in this very vulnerable population.
4. Psychiatry should follow all lab and EKG monitors necessary for medication they prescribe and make the necessary adjustments to the medication regimen so that the burden of monitoring does not fall on primary care. When they are in need of primary care's consultation to manage side effects of psychotropics, then the necessary consultation should be ordered and communicated.
5. Lithium and anti-epileptic medications need to follow strict monitoring protocols as evidenced by two individuals who became toxic on these medications requiring hospitalization. This is a medically fragile population that requires due diligence to avoid such toxicities.

Appx A: Pharmacy/Therapeutics	
	Steps Taken to Assess Compliance: o Review of DUEs and P&T committee minutes o Discussions with the pharmacy director and the facility's Pharm.D.
	Summary of Monitor's Assessment: The DUE that was presented by the Pharm.D. at the time of the baseline visit was not in agreement with the expectation set forth in the health care guidelines. The P&T committee had met once in the past year, however, the work suggested in the health care guidelines was not accomplished according to the minutes provided for the meeting. There were quarterly drug regimen and polypharmacy reviews noted in each individual's record, however, they ranged from every two to six months. None of the records reviewed contained a prospective drug review as outlined by the health care guidelines.
Recommendations: 1. A working P&T committee should be formed to include the work outlined in the healthcare guidelines. This committee needs to include psychiatry. 2. DUEs, as outlined in the healthcare guidelines, should be developed at the P&T committee level. 3. Pharmacy needs to begin the process of compliance with both quarterly reviews and polypharmacy reviews for each individual. 4. Pharmacy needs to implement the use of prospective drug reviews.	

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADA	Americans with Disabilities Act
ADA	American Dental Association
ADR	Adverse Drug Reaction
AIMS	Abnormal Involuntary Movement Scale
ANC	Absolute neutrophil count
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APA	American Psychiatric Association
APC	Admissions and Placement Coordinator
ATP	Assistive Technology Professional
AU.D.	Doctor of Audiology
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BP	Blood Pressure
BSP	Behavior Support Plan
CAP	Corrective Action Plan
CCC	Clinical Certificate of Competency
CFY	Clinical Fellowship Year
CDDN	Certified Developmental Disabilities Nurse
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMA	Certified Medical Assistant
CME	Continuing Medical Education
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
CBC	Complete Blood Count
DADS	Texas Department of Aging and Disability Services
DAP	Data, Assessment, Plan
DCP	Direct Care Professional
DDS	Doctor of Dental Surgery

DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	U.S. Department of Justice
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EKG	Electrocardiogram
EMR	Electronic Medical Record
ER	Emergency Room
FAAA	Fellow, American Academy of Audiology
FAOTA	Fellow, American Occupational Therapy Association
FAST	Functional Analysis Screening Tool
FBS	Fasting Blood Sugars
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
HCG	Health Care Guidelines
HCS	Home and Community-based Services
HGA1c	Hemoglobin A1c
HRC	Human Rights Committee
HST	Health Status Team
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
IEP	Individual Education Plan
IM	Intramuscular
IMRT	Incident Management Review Team
IOA	Inter Observer Agreement
IPN	Integrate Progress Note
IQ	Intelligence Quotient
ISP	Individual Support Plan
LAR	Legally Authorized Representative
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LODR	Living Options Discussion Record
LOS	Level of Supervision
LPA	Licensed Psychological Associate
LRA	Labor Relations Alternatives
LSSLC	Lufkin State Supported Living Center
LVH	Left Ventricular Hypertrophy
LVN	Licensed Vocational Nurse

MAR	Medication Administration Record
MBS	Modified Barium Swallow
MD	Medical Doctor
MG	Milligrams
MI	Myocardial infarction
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRA	Mental Retardation Authority
MS	Master of Science
NA	Not Applicable
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nursing Operations Officer
NPO	Nil Per Os (nothing by mouth)
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
PA	Physician Assistant
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCM	Program Compliance Monitor
PCP	Primary Care Physician
PDP	Person Directed Planning
PDR	Physicians' Desk Reference
PECS	Picture Exchange Communication System
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Pharm.D.	Doctor, Pharmacy
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PIT	Performance Improvement Team
PMAB	Physical Management of Aggressive Behavior
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSP	Personal Support Plan

PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
QA	Quality Assurance
QABF	Questions About Behavioral Function
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
R	Respiratory Rate
RD	Registered Dietician
RN	Registered Nurse
SA	Settlement Agreement
SAP	Skill Acquisition Program
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SQ	Social Quotient
SSLC	State Supported Living Center
T	Temperature
TD	Tardive Dyskinesia
TIR	Tone, Inhibition, and Relaxation
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UA	Urinalysis
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulation
VPA	Valproic Acid