United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: December 5 - December 9, 2011

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICFMR) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

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

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

Methodology

In order to assess the facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the review, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review. **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. 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.

(b) **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. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

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

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.
g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

Executive Summary

First, once again, the monitoring team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at SGSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The facility director, Dr. Philip Baugh, was again extremely supportive of the monitoring team's activities throughout the week of the onsite review.

The Settlement Agreement Coordinator, Misty Mendez, was assigned primary responsibility for coordination of document preparation and coordination of activities during the onsite review. Ms. Mendez was appointed to this position since the last onsite review, thus, this was her first experience as SAC during an onsite review. Even so, she did an excellent job of assisting the monitoring team throughout the onsite week (as well as in the weeks prior to, and following, the onsite week) with all requests, information or documents, scheduling, and anything else needed to help the monitoring team conduct this review. Moreover, she was an active presence in a number of meetings in her role as SAC (e.g., see section E below). She was assisted by Stephanie Vretis, Ms. Mendez's assistant, who was also very professional and helpful.

Second, management, clinical, and direct care professionals continued to be eager to learn and to improve upon what they did each day to support the individuals at SGSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite review. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist SGSSLC in meeting the many requirements of the Settlement Agreement.

Third, as detailed in the full report and as the reader will see, the requirements across provision items vary greatly. Some require full organizational system actions, whereas others only require the creation of a document or the hiring of qualified staff. Below are comments on a few general topics regarding service operations at the facility.

- Continued progress: SGSSLC had made continued progress towards substantial compliance in most (though not all) provisions of the Settlement Agreement as indicated in the detail in the sections of the report to follow below. The monitoring team encourages the facility's management, clinicians, and staff to continue their efforts.

- Attention to Settlement Agreement: Facility staff and management were very aware of the Settlement Agreement. There was frequent reference to Settlement Agreement provision and provision items, often by provision item letter and number.

- Follow through: SGSSLC tended to follow through on projects and activities. For example, many of the activities described as new developments in the previous monitoring report had continued at the time of this onsite review.

- Use of performance improvement teams: SGSSLC and the QI Council continued to make good use of performance improvement teams.

- Facility self-assessment: SGSSLC provided its facility self-assessment, called the POI. The development of a useful POI has been an ongoing project for all of the SSLCs. Future revisions will be done in collaboration with DADS central office. In each of the sections of this report, the Monitor comments on the POI. Overall, the SGSSLC POI described actions the facility had taken that, in its opinion, were moving the facility towards substantial compliance, and actions it planned to take in the future. While this information was useful to the monitoring team, the POI should describe the activities the facility engaged in to assess its own performance, the results of this self-assessment, how these results were used to self-determine substantial compliance, and a set of action steps to move forward towards substantial compliance.

- Statewide self-monitoring tools. DADS central office had distributed self-monitoring tools that lined up with most provisions of the Settlement Agreement. These tools were meant to be more user-friendly and appropriate for use by facility staff than were previous versions. Additional attention will need to be made to ensure the tools are updated and that they are implemented reliably (see section E below). At SGSSLC, these tools were being taken very seriously, that is, they were being used regularly and data were reviewed regularly. As the facility moves forward with this process, the monitoring recommends that the content of each tool be reviewed for appropriateness and correctness (i.e., validity). Revisions are needed. Some items in each tool will need to be reworded, others deleted, and others added. This activity will need to occur along with DADS central office.

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

Restraints

- Over the past six months, 598 restraints occurred. Of these, 304 were programmatic restraints (implementation of safety plan), 294 were emergency restraints, 520 were personal hold restraints, 3 were mechanical restraints (body wrap), and 75 were chemical restraints. Seventy-five individuals were the subjects of restraints. Restraints resulted in injuries to individuals seven times. Three individuals accounted for 199 (33%) of the restraint incidents. Twenty-nine individuals had been restrained five or more times during the reporting period.

- While fewer individuals were restrained since the last monitoring visit, there was a 27% increase in the number of restraint incidents. The Restraint Reduction Committee acknowledged that many restraint incidents at the facility might have been avoided if consistent, appropriate interventions and programming were in place at the time.
- Actions taken by the facility to address restraint usage since the last monitoring visit included:
    - Restraint audits were being completed monthly using the section C audit tool developed by the state office for a sample of restraints.
    - Data collected from completed audits were reviewed by the Restraint Reduction PIT.
    - Shift Coordinators had been designated as restraint monitors.
    - PSTs received retraining on restraint review requirements.
    - The Restraint Reduction Committee had collected information from staff and individuals on strategies that were successful for avoiding restraint.
    - New training curriculum had been developed and reviewed by the Restraint Reduction Committee to supplement current restraint training.

<u>Abuse, Neglect, and Incident Management</u>

- The facility Incident Management Coordinator and facility investigators were knowledgeable and fastidious in regards to ensuring investigations were completed when incidents occurred at the facility. The facility had a relatively small incident management department when considering that there were, on average, over 100 incidents and allegations per month to be investigated and only two full time investigators. Although, a number of steps had been taken to ensure incidents and injuries were appropriately investigated and corrective action was documented, there had not been a focused effort on addressing systemic issues that placed individuals at risk for abuse, neglect, and injury.
- Investigation of 694 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility from 5/1/11 through 9/30/11 (five months). Of these 694 allegations, 39 (6%) were confirmed allegations by DFPS (including 17 allegations of abuse [verbal or physical] and 22 allegations of neglect), 480 (69%) were unconfirmed allegations, 36 (5%) were inconclusive, 35 (5%) were unfounded allegations, and 104 (15%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect. This was an increase of 16% in the number of allegations reported in the prior five months.
- There were a total of 1735 injuries reported between 5/1/11 and 11/31/11 (seven months). These 1735 injuries included 24 serious injuries resulting in fractures or sutures. It was not evident that the facility was adequately addressing the high number of injuries with preventative actions. Documentation indicated that a significant number of injuries were resulting from behavioral issues, including peer-to-peer aggression.

- The facility, however, had taken a number of steps to address incident management. Action was primarily targeted toward reporting and documentation of incidents rather than reduction and prevention of incidents. Some positive steps taken included:
    - An audit process was implemented to test staff knowledge of steps for reporting incidents.
    - The DADS Section D Monitoring Tool was implemented.
    - A flowchart was developed for reporting unknown injury investigations.
    - A complaint line was established for individuals to report complaints regarding services at the facility.
    - The Incident Management Director began presenting DFPS final reports to the Incident Management Committee for review.
    - Additional positions were approved for the incident management department.

Quality Assurance

- SGSSLC made continued progress towards achieving substantial compliance with the items of this provision since the last onsite review. The QA director was instrumental in the progress that the facility was making.
- SGSSLC had begun to develop a listing/inventory of data collected at the facility. A QA plan still needed to be written, however, the QA matrix was in place and continued to improve. A QA report was completed each month. The most recent report contained a great deal of information, such as graphs, tables, and narratives.
- QI Council met regularly, about twice each month, since the last review. Data were presented, Settlement Agreement sections were reviewed, and PITs provided updates. There was good participation during the three hour QI Council meeting observed by the monitoring team.
- A system of managing corrective actions was developing. A 26-page listing of corrective action plans was created, though its utility and whether it met the intention of provisions E2-E5 were not clear.

Integrated Protections, Services, Treatment, and Support

- DADS had recently initiated a thorough review of the PSP process and hired a set of consultants to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. Comments are more generalized for this section of this report in light of the fact that SGSSLC was still waiting on initial technical assistance from consultants before fully implementing the new and updated person centered planning process.
- Two of the three PSP meetings scheduled during the review week were observed by the monitoring team. In meetings observed, the QDDPs were attempting to ensure that all necessary information was covered during the PST meeting. Meetings attended were lengthy and somewhat fragmented in discussing supports.
- There was minimal progress being made on developing plans that would lead to a more meaningful day for individuals. PSTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want.

- Quality assurance activities with regards to PSPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the PSP development process.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- The SGSSLC staff invested significant time in working towards achieving compliance with this provision. Continued progress was noted in this area, evidenced by the various initiatives that were implemented. The medical director remained in the lead role and was aware of the importance of adequately integrating clinical services. Those efforts were quite visible to the monitoring team throughout the week of the review.
- There were several positive findings related to collaboration and integration. Unfortunately, there was also evidence that in some areas there was a near total disconnect among the clinical services and this contributed to a lack of positive outcomes for individuals. This will likely improve as the facility director assumes the lead role and fosters even a greater sense of collaboration and accountability among the various disciplines.
- The facility had written a policy for section H, and this provided a staring point for moving towards substantial compliance. During discussions, it was acknowledged that this was a very important provision and much work had gone into developing the policy. There were many activities occurring in the facility that were connected to provision H, but were not clearly identified as such. Many of the activities in this provision are related to determination of quality and will require input on the part of the QA department.
- Overall, the monitoring team found that routine assessments were being completed, but in many areas these assessments were not being completed in a timely manner. Additionally, the content of the assessments in many areas will need improvement. The monitoring team also noted that there were some examples of clear deficits in the response of clinicians to a change in status.

At-Risk Individuals

- Some steps SGSSLC had taken towards compliance with this provision included:
    - All individuals had PST meetings to address their risks utilizing the new At Risk Process.
    - The facility began using the statewide Section I audit tool to assess compliance.
    - An at-risk committee was formed and staff were assigned to begin monitoring the at risk process during annual PST meetings.
    - PSTs were retrained on the at-risk policy and guidelines for determining risk levels.
    - An interdisciplinary team of discipline heads held At-Risk Oversight Modeling Sessions and provided feedback to PSTs regarding risk rating rationales.
    - The facility began using an interview tool to quiz direct support staff on risks for individuals who they support.
    - Consultation protocols were revised to ensure RN case managers notified team members of changes in health status or health management plans resulting from medical consultations.

- PSTs, however, were not always accurately identifying risk for individuals. All staff needed to be aware of and trained on identifying crisis indicators.

Psychiatric Care and Services

- The psychiatry department had seen some improvement with development of a comprehensive 90-day outline for the psychiatry review. Additionally, the clinic was organized in that the individual and staff were in attendance at clinic, the psychiatrist received clinical information during clinic, and discussions regarding the individuals were more detailed. These improvements resulted in positive changes in the process of psychiatry clinic.
- The psychiatric practitioners were encouraged to document their activities and gather supporting data to reflect the psychiatry department's progress with implementation of the provisions in section J, with the goal of the establishment of a psychiatric system that met generally accepted professional standards of care. There was lack of data, and when supplied, was incomplete, sometimes undated, and therefore, deemed unreliable.
- It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, collaboration regarding case formulation). The physician was not provided appropriate data in order to make decisions regarding pharmacology in an objective manner, and per a review of records, made medication additions or adjustments in the absence of data regarding specific clinical indicators. The staff from each discipline were aware of the challenges and the need for increased structure and integration.

Psychological Care and Services

- There has been continued progress. This included that four psychologists completed coursework for board certified behavior analyst (BCBA) certification. All of remaining psychologists that write Positive Behavior Support Plans (PBSPs) either had their BCBA (one individual) or were enrolled in BCBA coursework. There were also continued improvements in the data collection system, the beginning of the collection of replacement behaviors, the establishment of the collection of inter-observer agreement (IOA) data, the establishment of treatment integrity data, and improvements in the quality of the functional assessments and PBSPs. There were substantial improvements in ensuring that therapies and psycho-educational sessions were goal directed, with measurable goals and progress towards those goals.
- The areas that the monitoring team suggest that SGSSLC focus on during the next six months included ensuring that internal peer review occurs at least weekly, and external peer review monthly, establishing data collection reliability, determining reliability goals, and piloting a method to ensure that they are achieved in at least one home. In addition, the facility needs to ensure that full psychological assessments contain all the necessary

components, that there is an increase in the number of functional assessments conducted, and that annual psychological assessments contain all the necessary components.

Medical Care

- The medical staff of the facility was dedicated to serving the individuals at the facility. Although the results of this review found many gaps in the provision of care, the monitoring team noted many facility process and systems issues that contributed to these findings. For instance, the facility lacked adequate IT infrastructure to support databases for tracking essential information. Furthermore, routing of consultations remained problematic and appeared to contribute to breakdowns in follow-up. A lack of stability in the pharmacy department resulted in QDRRs that provided a paucity of information on complicated drug regimens. Record reviews alluded to gaps in the appropriate notification of physicians regarding a change in status. Documentation by medical providers had made a small degree of improvement, but heavy caseloads likely impacted the ability to document frequently.
- There were some noteworthy improvements, but unfortunately, most of the changes had not had enough time for implementation to effect any detectable change. New clinical guidelines were issued by state office along with a new preventive care flowsheet. A daily, integrated clinical services meeting was implemented in October 2011 to bring many disciplines together to discuss relevant clinical issues. That meeting, however, occurred at the end of the workday, probably diminished the relevance of the meeting compared to it being held first thing in the morning.
- External reviews continued to be completed, but the focus of the reviews remained on processes without any meaningful assessment of clinical outcomes. While the facility conducted mortality reviews per policy, it appeared that follow up on recommendations remained problematic.

Nursing Care

- The Nursing Department continued to struggle over how to meet the provisions of Section M, and staff were somewhat frustrated over taking one step forward and, sometimes, two steps backward. For example, a review of the department's own self-assessment data revealed some initial improvements, then a decline across several provisions of Section M, with documentation and assessment being two significant examples of where this had occurred.
- The Nursing Department continued to be affected by high turnover and a high number of vacancies, with 17 vacant positions across all levels of the Nursing Department, which was 20% of the department's total workforce.
- Notwithstanding the struggles, over the past six months, the Nursing Department developed and implemented policies and procedures, enhanced and improved some existing systems, and invested considerable time and

resources in improving the accountability and administration of medications and reduced medication errors and unexplained variances.

- There was evidence that nurses failed to conduct adequate and appropriate assessments of individuals with high risk conditions and observable and notable changes in their health status; nurses failed to administer medications in accordance with standards of practice, and as a result of one particularly egregious failure, it was necessary for the monitoring team to intervene in order to protect an individual from receiving six times more than the prescribed amount of medication.
- There were also a number of problems with the development and implementation of an adequate infection prevention and management program at the facility, as well as evidence that nurses violated basic standards of infection control during their delivery of nursing care.
- In addition, despite the presence of the QA nurse's thorough analyses of nursing care and comprehensive, clinically significant, prudent recommendations to improve care, there were a number of failures by the Nursing Department to implement recommendations at all and/or in a timely manner, and/or provide reasonable explanations for why recommendations were not carried out.

Pharmacy Services and Safe Medication Practices

- The pharmacy had taken several steps to move towards substantial compliance. The most important step was the hiring of a full time clinical pharmacist. Within the first two months of employment, the clinical pharmacist had done a through assessment of the issues and became very familiar with the requirements of the Settlement Agreement. For the most part, policy and procedures had been developed and implemented just prior to the onsite review. Much of the data provided were based on previous processes. Nonetheless, it was good to see that the hiring of a full time clinical pharmacist had resulted in the very beginning of forward movement.
- Since the last onsite review, the pharmacy staff completed training on the use of the WORx software. It was anticipated that additional training was needed to fully utilize the capabilities of the system. A new policy related to prospective pharmacy reviews was implemented in December 2011. The data submitted to document communication between prescribers and pharmacists, however, did not provide adequate evidence that these actions occurred.
- A new procedure related to the completion of Quarterly Drug Regimen Reviews was implemented just prior to the review. Unfortunately, the reviews were woefully inadequate in terms of content and actual formatting. There was an overall lack of professionalism in completion of the evaluations, with some documents containing doodling and name tracings. Moreover, numerous records encountered simply lacked the presence of the QDRRs for the last two quarters.

- A DUE policy was also developed and implemented. The policy did a nice job of summarizing the process and outlining requirements as specified in the Health Care Guidelines. Once again, this change occurred just prior to the review. DUEs were not completed as required, due to the lack of a clinical pharmacist for several months
- The facility made progress with the medication variance system. The issue of overages and shortages was addressed, and significant improvement was measured. Many other steps occurred, such as increased nurse training that should contribute to improving the safety of the medication use system.

Physical and Nutritional Management

- The Habilitation Therapies department demonstrated a lot of effort with a substantial number of work products produced related to this provision. There were many new systems initiated. The director clearly reviewed the previous report for all related sections and developed strategies to address issues identified.
- The PNMT was fully constituted, though only the nurse was dedicated, due to extremely low staffing. She was competent, energetic, and served as a strong point person for consistency and connection to other departments and programs. The monitoring team observed a meeting that showed that the PNMT was developing and refining a process to address new referrals for assessment and PNM supports, as well as to review individuals with other PNM-related concerns
- The facility still had some way to go toward more effective discussions and decisions related to rating risk as well as in the development of appropriate action plans. The PNMT was integrating actions they need to take within the existing PST action plans. As their system evolves, attend to the tracking of clinical indicators and doing trending with analysis.
- The PNMPs were of a consistent format and each was current within the last 12 months, though only a small number had been converted to the new format. Implementation of these plans, while improved, still posed challenges for professional staff and the PNMPCs to promote continued competency and compliance of direct supports staff. Positioning and transfers continued to be a concern.
- The PNMT evaluations reviewed were essentially record reviews and did not reflect new data or more current assessments by any core team members. In addition, there was no evidence that the PNMT reviewed the findings of monitoring conducted to assess compliance with the PNMP or other plans or their effectiveness in meeting the intended goals as an aspect of the PNMT assessment.
- Mealtimes were observed in a number of homes that had been observed during previous onsite visits. There was evidence of improvements related to compliance with the dining plans. Exceptions were primarily regarding food service issues with food preparation for chopped diets; the pieces were too big in some cases and too processed in the case of the fruits and vegetables.

Physical and Occupational Therapy

- Staffing levels had remained stable since the previous review and remained inadequate to accomplish all the roles and responsibilities required.
- The assessment process observed during this review, however, had significantly improved. The report content had also improved, though the analysis of findings was scattered throughout the report and did not appear to be based on all of the objective data.
- The OT and PT clinicians conducted their annual assessments together and, in some cases, the SLPs participated in the assessment process as well. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services.
- Updates of assessments sometimes were for an assessment that had been completed as many as 16 years earlier. An assessment that old could not be considered comprehensive.
- The measureable outcomes were limited to those related to risk management only and not to promote a change in functional status or skill acquisition. Many were not actually stated in measurable terms.
- There was a continued need for improved staff attention to the details of proper positioning and alignment in wheelchairs and dining chairs and compliance with the PNMPs. No one was observed being repositioned prior to the meal, and a number of individuals were not appropriately aligned or supported. Attention to personal body mechanics used by staff also continued to need improvement.
- Some staff were more confident in their responses to the monitoring team's questions and appeared have a better understanding of why they were doing what they were doing in relationship to the PNMP. This was likely associated with the skills drills and ongoing coaching and drills with staff related to risks and the rationale for interventions and supports.

Dental Services

- The dental clinic continued to provide basic dental services to individuals supported by the agency, but there was no demonstrable advance towards achieving substantial compliance. Progress noted at the last visit related to desensitization and implementation of suction toothbrushing showed regression. The staff were very clear that the resignation of the full time hygienist in June 2011 created a significant problem because she was responsible for administering most of the programs related to the clinic. Creation of that vacancy resulted in a loss of momentum.

- Databases were created to track appointments, but it was documented that the data generation was problematic. This was evident from the various sets of data provided.
- Compliance with the requirement for completion of annual assessments varied widely from month to month and the percentage of failed appointments showed no significant improvement**.** The reported oral hygiene ratings showed some improvement.
- Following the last monitoring visit, there did not appear to be any development of desensitization plans for several months.

Communication

- Progress with completion of communication assessments per the Master Plan was slow, in large part, due to extremely low staffing levels. This plan prioritized individuals based on their needs for communication supports, particularly AAC.
- A number of individuals were identified as requiring a re-evaluation in the last year that had not been provided per the Master Plan (50% of those identified as Priority 1). Still, others were completed, but after the PSP meeting. Without a current and comprehensive assessment, it is not possible to identify communication needs for AAC, communication programming, and intervention.
- Consistency of the implementation of AAC and communication plans continued to be problematic. Clinical staff had limited time for inserting themselves in the environments and daily routines of individuals, but this will be key to effective assessments, the selection of meaningful and useful communication supports, the development of communication programs, and to provide modeling of how to be an effective communication partner. There had also been a concerted effort in working with the teams related to communication, particularly for those who had challenging behaviors.
- Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority.

Habilitation, Training, Education, and Skill Acquisition Programs

- A wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training were assessed. 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.
- There were improvements since the last review, including establishment of a skill acquisition PIT group to integrate Skill Acquisition Plans (SAPs) into day programming, and inclusion of all components necessary for acquiring new skills. Facility staff began the use of forward and backward chaining for the training of SAPs and planned to expand the staff who write, monitor, and implement SAPs.

Most Integrated Setting Practices

- SGSSLC continued to make progress towards meeting the many items of this provision. The number of individuals who were placed was at annual rate of approximately 10 percent (13 placements in six months, census of 241) and approximately 14% of the individuals at the facility were on the active referral list (i.e., 33 individuals). This showed stable/increasing trends.
- Data for individuals who were hospitalized for psychiatric reasons, incarcerated, or who had run away from their community placements were not available. A detailed review/root cause analysis should be conducted for any of these or similar types of significant post-move events.
- A major process change was soon to be underway regarding both the PSP meeting and the PSP document (also see section F). The new process should improve the PST's identification of protections, services, and supports and the inclusion of the determinations of professionals regarding community referral. SGSSLC had made some progress in trying to identify obstacles to individuals living in the most integrated setting appropriate to their needs and preferences. This was evident in each PSP and in a new spreadsheet.
- The APC attended QDDP meetings and discussed the section T requirements that impact the PSP process and the activities of the QDDPs. This was good to see and should probably become a regular part of the APC's duties, especially given the importance of the QDDPs in meeting the requirements of section T.
- PST members were very involved in the placement activities of the individuals who were referred. They helped choose possible providers, set up and attended visits to residences and day programs, and actively participated in supporting the individual to make the best possible choice of providers.
- The CLDP meeting observed by the monitoring team, however, was one of the most boring meetings observed during the week of the onsite review. Even the individual himself fell asleep during the meeting. The APC and the transition specialists should review the format and content of the meeting so that future meetings can be more engaging and so that the important topics can be discussed earlier in the meeting.
- Twelve CLDPs were reviewed along with their attachments. A variety of individuals across the entire facility were placed, extra efforts were given to those referrals that were more than 180 days old, and PST participation was strong. Unfortunately, there was insufficient attention paid to individuals' past histories, and recent and current behavioral and psychiatric problems, and there was, again, an overall failure to capture what was important to the individual. There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success, even though these were indicated as being important to many of the individuals. Jobs for individuals remained an issue.
- Post move monitoring was conducted regularly and for all individuals, as required. This was a major feat for the PMM, especially given that individuals were placed all over the state. Moreover, she visited both the day and residential sites, and conducted the post monitoring visits at whatever time made the most sense based on the individual and his or her schedule. As a result, reviews sometimes occurred over two consecutive days, and/or

in the late evenings. The areas in need of improvement were the format of the new post move monitoring tool, and the need for more active follow-up by the PMM when there were problems with supports and/or the overall placement of the individual.

Consent

- Some positive steps that the facility had taken in regards to consent and guardianship issues included that revisions had been made to the facility's rights assessment, the Rights Protection Officer provided training to QDDPs on how to better determine ability to give informed consent, and information on guardianship was presented to families. The human rights, self-advocacy, and guardianship committees continued to meet regularly.
- The Rights Protection Officer continued to work with local agencies to pursue advocates for individuals. An audit process had been implemented using the statewide Section U audit tool.
- While the facility maintained a list of individuals needing an LAR, PSTs were not adequately addressing the need for a LAR or advocate.

Recordkeeping Practices

- SGSSLC demonstrated continued progress and had made a number of improvements in recordkeeping activities and records management. The URC was organized, knowledgeable about all of the requirements of provision V, detailed in her work, and tenacious in her quality assurance audit reviews.
- The active records were neat and organized. Records contained documents as per the table of contents guidelines. There were, however, documents filed in the wrong individual's active record, legibility of entries continued to be an issue that needed to be addressed, and signatures and dates were missing from some documents.
- There were individual notebooks for all individuals, however, in many of the homes, the individual notebooks were kept in the locked records room. This continued to raise the question of how data could be collected and recorded reliably and accurately if the individual notebooks were stored in the records rooms. Master records were maintained in the same satisfactory manner as during the last onsite review.
- Tracking and management of state and facility-specific policies was done on a spreadsheet. It indicated continued progress. The tracking should also include information related to central office review. Further, a system of implementation and training of relevant staff needs to be created.
- The URC was now completing five reviews per month, as required. Overall, the reviews were done in a consistent and very detailed manner. Across the 10 audit reviews, there was a consistency in the issues and problems identified by the URC. Upon completion of the review, the URC let relevant managers and clinicians know about what needed to be corrected. This was a very new part of the process for the URC.

- The data from the statewide monitoring tools were entered into the state database. The URC created a set of graphs showing the performance of the facility on the items of the statewide tool. These data were submitted to the QA department and were included in the monthly QA report. A next step is for the URC to create a set of graphs regarding the conduct and outcomes of the audit review process.
- To address the facility's use of the unified records to make treatment and care decisions, the URC had done brief interviews of a number of PST members. These data were interesting, but were not used by the facility. More activities will need to be undertaken. Direction will likely be provided by state office in the near future.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of SGSSLC. 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 continues to look forward to continuing to work with DADS, DOJ, and SGSSLC. Thank you for the opportunity to present this report.

II. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o SGSSLC Policy: Management of Inappropriate Behavior Revised 2/10/06 o SGSSLC Policy: PMAB Investigations Revised 2/10/06 o SGSSLC Policy: Medical/Dental Restraint and Sedation Minimum Guidelines Dated 9/9/05 o SGSSLC Policy: Response to Behavioral Emergencies Revised 11/18/10 o SGSSLC Policy: Restraint Notification Process and Responsibilities of Restraint Monitors and Health Care Professional dated 3/31/11 o SGSSLC Policy: Use of Restraint dated 4/14/11 o SGSSLC Procedure: Consumer Emergency Relocation dated 12/3/04 o SGSSLC Policy: Physician's Notification and Orders for the Use of Restraint dated 12/18/09 o Restraint Documentation Guidelines for SSLCs dated November 2008 o SGSSLC FY11 Trend Analysis Report o SGSSLC Plan of Improvement (POI) o SGSSLC Section C Presentation Book o Section C completed restraint audits summaries for June 2011 – August 2011 o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum o Fundamentals of Managing Behavioral Emergencies Curriculum o List of all restraints used for crisis intervention for the past six months o List of all chemical restraints for the past six months o List of all medical restraints for the past six months o List of all dental restraints for the past six months o List of all restraint related injuries for the past six months o SGSSLC "Do Not Restrain" list o List of individuals with desensitization plans o Dental desensitization plans for: • Individual #261, Individual #217, Individual #201, Individual #130, Individual #389, and Individual 385. o Restraint Reduction Committee meeting minutes for past six months o Behavior Support Committee meeting minutes for past six months o List of all individuals who had a Safety Plan for Crisis Intervention o Training transcripts for 24 SGSSLC employees o Documentation for pretreatment medical sedation for Individual #38 dated 8/4/11 and 9/2/11 o Sample of Daily Incident Review Team Meeting Minutes o Positive Behavior Support Plans (PBSPs) for:

- Individual #153, Individual #292, Individual #346, Individual #215, Individual #116

o Safety Plans for:
- Individual #292, Individual #346, Individual #215, and Individual #116

o Personal Support Plan Addendums (PSPAs) for:
- Individual #153, Individual #292, Individual #254, Individual #85, Individual #247, Individual #23

o A sample of restraint documentation for behavioral intervention including:

Individual	Date/Type P = Physical C = Chemical	Restraint Checklist and Face to Face Assessment	PSP	PBSP	Safety Plan
#116	10/18/11 P	x	8/18/11	10/26/11	7/15/11
	10/18/11 C	x			
	8/13/11 P	x			
	8/11/11 P	x			
	8/7/11 P	x			
	8/2/11 P	x			
	7/22/11 P	x			
	7/22/11 C	x			
	7/3/11 P				
	7/3/11 C	x			
	6/24/11 P	x			
	5/19/11 P	x			
	5/9/11 P	x			
#243	10/30/11 P	x	2/18/11 4/11/11 (A) 4/19/11 (A) 6/17/11 (A)	12/17/11	7/29/11
	10/24/11 P	x			
	8/14/11 P	x			
	7/14/11 P	x			
	6/25/11 P	x			
	6/15/11 P	x			
	6/15/11 P	x			
	6/11/11 P	x			
	6/10/11 P	x			
	6/10/11 C	x			
#194	9/18/11 P	x	9/13/11 6/21/11 (A) 7/6/11 (A) 9/6/11 (A)	9/20/10	9/20/10
	7/30/11 P	x			
	7/9/11 P	x			
	7/7/11 P	x			

	7/7/11 P	x			
	7/7/11 P	x			
	7/7/11 C	x			
	6/12/11 P	x			
	6/12/11 P	x			
	6/12/11 P	x			
#6	11/7/11 C	x	10/31/11		
	11/5/11 P	x			
#355	11/6/11 P	x	11/23/11		
#157	11/5/11 P	x	11/22/11		
#193	11/7/11 C	x	10/3/11	10/24/11	
#148	11/4/11 C	x	2/10/11	2/18/11	
#75	12/4/11 C				

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Jawlown McCleery, Incident Management Coordinator
- Michael Davila, QDDP Coordinator
- Roy Smith, Rights Protection Officer
- Gary Flores, Director of Day Services
- Michael Fletcher, QDDP Educator
- John Church, POI Coordinator
- Robb Weiss, Chief Psychologist

Observations Conducted:

- Observations at residences and day programs
- Unit 1 Morning Meeting – 12/6/11
- Incident Management Review Team Meeting 12/6/11 and 12/7/11
- Human Rights Committee Meeting 12/7/11
- Restraint Reduction Committee 12/8/11
- Annual PSP meetings for Individual #285

Facility Self-Assessment:

SGSSLC submitted its self-assessment, called the POI. It was updated on 11/22/11.

The facility's Plan of Improvement for section C indicated that the facility had implemented several new processes to address deficiencies noted in the last monitoring report. These processes are discussed below in regards to meeting substantial compliance for each provision in section C. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement

	Agreement. The findings from the facility's monthly audit process were summarized in the POI. Data from the audit tool were summarized in the POI, but the compliance rating assigned did not necessarily reflect data collected. For example, the facility assigned a noncompliance rating for C2. The comment/status section noted that data reviewed from the section C monitoring tool for this provision was 100% in each month from June 2011 through September 2011. The facility was aware of problems with implementation, monitoring, and documentation of restraints, and was in the beginning stages of addressing those issues. Therefore, the monitoring team rated C1 as being in noncompliance. The facility rated itself as being in substantial compliance with item C3 and in noncompliance with the other provision items. The monitoring team agreed with the facility's self-assessment ratings (except the monitoring team rated item C7g as being in substantial compliance). Positive steps taken to address noncompliance by the facility are noted in the summary section. The Restraint Reduction Committee had been reorganized and was beginning to look at systemic issues in regards to restraints. The committee was taking a broader approach by looking at the audit of documentation, as well as, reviewing restraint videos, evaluating training procedures, reviewing restraint trends, and interviewing staff and individuals involved in restraints. Findings from this comprehensive review were not reflected in the POI. Reducing the number of restraints at the facility will require a system wide philosophical change in how restraints are viewed and a multidisciplinary effort among all departments.
	Summary of Monitor's Assessment: Based on information provided by the facility in a list of all restraints used for crisis intervention, between 5/24/11 and 11/14/11: • 598 restraints occurred. • 304 were programmatic restraints (implementation of safety plan); • 294 were emergency restraints; • 520 were personal hold restraints; • 3 were mechanical restraints (body wrap); and • 75 were chemical restraints. • Seven restraint incidents resulted in injuries to individuals. • 75 individuals were the subjects of restraints. The three individuals with the greatest number of restraints (Individual #116, Individual #243, and Individual #194) accounted for 199 (33%) of the restraint incidents. Twenty-nine individuals had been restrained five or more times during the reporting period. According to the facility POI, action taken by the facility to address compliance with section C since the last monitoring visit included:

	• Restraint audits were being completed monthly using the section C audit tool developed by the state office for a sample of restraints. • Data collected from completed audits were reviewed by the Restraint Reduction PIT. • Shift Coordinators had been designated as restraint monitors. • PSTs received retraining on restraint review requirements. • The Restraint Reduction Committee had collected information from staff and individuals on strategies that were successful for avoiding restraint. • New training curriculum had been developed and reviewed by the Restraint Reduction Committee to supplement current restraint training. All home supervisors will now be required to complete supplemental training. While fewer individuals (5%) were restrained since the last monitoring visit, there was a 27% increase in the number of restraint incidents. Issues identified during the previous monitoring visit continued to be areas of concern regarding the documentation, monitoring, and review of restraints. The Restraint Reduction Committee acknowledged that many restraint incidents at the facility might have been avoided if consistent, appropriate interventions and programming were in place. As noted in section D, consideration should be given to factors that generally contribute to behavioral incidents, such as living areas, levels of supervision, staff training, and meaningful activities. As the facility moves forward, all departments will need to take an integrated, aggressive approach to restructuring the environment, supports, and programming to address these issues.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written	A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral incidents. Sample #C.1 was a random sample of restraints for the three individuals with the greatest number of restraints and six other individuals (with the most recent restraints). The individuals in this sample were Individual #116, Individual #243, Individual #194, Individual #355, Individual #148, Individual #6, Individual #157, Individual #75, and Individual #193. • Individual #116 had the greatest number of restraints, accounting for 114 of the restraints for crisis intervention in the six months prior to the monitoring visit. • Individual #243 had the second greatest number with 49 of the restraints. • An Individual #194 had 47 restraints. <u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training, that prone restraint was prohibited. Video surveillance from 9/23/11 showed that Individual #85 was placed in a prone	Noncompliance

#	Provision	Assessment of Status	Compliance
	policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	restraint lasting 16 minutes. The prone restraint was reported to DFPS as an abuse allegation and all three employees involved in the restraint were dismissed. Based on a review of 40 restraint records for individuals in Sample #C.1 involving eight individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> The facility policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner, for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included 40 restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 38 of the 40 records (95%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. The following descriptions did not indicate an immediate and serious threat. o The restraint checklist for Individual #243 dated 6/11/11 indicated that she was restrained after hitting another individual for no reason. Documentation did not indicate that her aggression continued or that she remained a danger to others after hitting the other individual. o The restraint checklist for Individual #148 dated 11/4/11 only noted "extreme agitation" in the area describing behavior that resulted in restraint prior to receiving a chemical restraint. • For the 40 restraint records in the sample, a review was completed of <u>the description of events leading to behavior that resulted in restraint</u>. The checklists reviewed described the individual's behavior prior to the restraint, but only 14 (35%) restraint checklists in the sample indicated either what activity the individual was involved in at the time of the restraint or what was occurring in the environment that might have triggered the behavior leading to restraint. • Examples where staff adequately described events leading to the behavior: o The restraint checklist for Individual #38 dated 11/7/11 noted "returned to the home from the infirmary. She was very upset about having to return because there was no cable in bedroom. She was also afraid someone was going to hit her." o The restraint checklist for Individual #194 dated 7/30/11 indicated that she was upset because her CD was missing. o The restraint checklist for Individual #116 dated 8/7/11 noted that she	

#	Provision	Assessment of Status	Compliance
		was agitated because she could not reach her father by phone. o The restraint checklist for Individual #75 dated 12/2/11 indicated that she was upset because her boyfriend was in the hospital. • Some examples where events leading to restraint were not adequately documented included: o In the area for the description of events on the restraint checklist for Individual #243 on 8/14/11, staff documented "was hitting staff repeatedly and staff could not back away." o On the restraint checklist for Individual #116 dated 10/18/11 the description of events leading to the behavior noted "was agitated, she was scratching and biting self, tore clothes off." Staff did not document in what activity the individual was involved prior to the incident. o Similarly, the restraint checklist for Individual #116 dated 6/24/11 documented "displaying SIB by biting her left hand after numerous verbal prompts, behavior still continued." • In 37 of 40 the records (93%), staff documented that restraint was used only after a graduated range of less restrictive measures had at least been attempted or considered, in a clinically justifiable manner. Exceptions were: o A restraint checklist for Individual #355 dated 11/6/11 indicated that a basket hold, then horizontal hold, was implemented when verbal prompts were unsuccessful. o The restraint checklist for Individual #6 did not document what interventions were attempted prior to the administration of a chemical restraint. o The restraint checklist for Individual #75 dated 12/4/11 indicated that a highly restrictive chemical restraint was used after an attempt to prompt replacement behavior was not effective. Without good documentation of what preceded the behavior, it was difficult to identify whether adequate steps had been taken to address the behavior before the restraint was applied to allow a determination to be made that the procedures were the least restrictive necessary. Therefore, it was not clear that all restraints used were the least restrictive intervention necessary. It was not evident that restraints were not used in the absence of, or as an alternative to, appropriate programming and treatment. As noted above, documentation did not always indicate what activities individuals were involved in prior to restraint. Based on observations in the homes and day program building, although there was progress made in overall engagement data being collected, engaging individuals in more individualized and meaningful programming of interest may reduce behavioral incidence leading to restraints, especially for those individuals who were restrained the most frequently.	

#	Provision	Assessment of Status	Compliance
		Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 40 restraints, 40 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility provided a list of medical pretreatment sedation restraint or medical restraints between 5/25/11 and 9/2/11 (dental data were not submitted): • 3 individuals were the subject of restraints, • 30 incidents of restraint occurred. Additionally, a list of individuals with medical or dental desensitization plans was requested from the facility. A list of desensitization plans referred to as Systematic Desensitization Programs (SDPs) included five individuals. Only one of the three individuals that was the subject of medical/dental restraint was included on this list. The facility was not in compliance with this provision item. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, as well as all interventions attempted prior to restraint. Further, it was not evident that treatment and programming were being consistently implemented, thereby affecting the number of behavioral incidents leading to restraint. Desensitization programs should be developed for those individuals requiring the use of pretreatment sedation for routine medical appointments.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the nine individuals in Sample #C.1 were reviewed. Of these, three of the individuals had a Safety Plan for Crisis Intervention (SPCI) that gave direction for the use of restraint. The SPCIs did not give release criteria. Thirty-six individuals at the facility had an SPCI in place at the time of the review. A sample of restraint documentation for 31 physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Twenty-nine of 31 (94%) restraints reviewed staff documented that the individual was released immediately when no longer a danger. Restraints in the sample lasted from less than one minute to 30 minutes in duration, however, documentation did not support that in all of these cases the individual was released as soon as he or she was no longer an immediate risk. Four of the restraints in the sample for Individual #116 lasted 30 minutes, the maximum duration before attempting release according to the facility policy. Release was not attempted prior to the actual release in those four instances.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The restraint checklist for Individual #116 dated 8/11/11 indicated that she was released after 30 minutes due to "restraint time limit." Documentation indicated that she was struggling against restraint, attempting self injurious behavior, attempting aggression and was agitated at the initiation of the restraint, 15 minutes into the restraint, and at the point she was released. She was not restrained again following release, which may have indicated that release could have been attempted earlier. Staff completing the restraint checklist for Individual #194 dated 6/12/11 indicated that she was released from restraint due to a medical emergency (details were not provided). SPCIs should specify specific behavioral indicators to identify when release from restraint should be attempted based on knowledge about that specific individual. An attempt should be made to release an individual from restraint as soon as staff determines that he or she does not pose an immediate danger. Not all individuals who are displaying behaviors described in the action/release code section of the restraint checklist (i.e., struggling against restraint, agitated, yelling, or cursing) are an immediate risk of danger to themselves or others. The facility was not in substantial compliance with this item.	
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	Review of the facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved verbal and redirection techniques, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • Twenty-four (100%) had current training in RES0105 Restraint Prevention and Rules. • 16 of the 17 (94%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. • Twenty-four (100%) had completed PMAB training within the past twelve months. • 17 of the 17 (100%) completed PMAB refresher training within 12 months of previous restraint training. The facility POI indicated that the facility was in substantial compliance with training	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	supervision of any individual in restraint.	requirements in regards to restraints. A review of a sample of training documentation supported substantial compliance with C3.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 40 restraint records (Sample #C.1), 40 (100%) indicated that restraint was used as a crisis intervention (i.e., emergency or programmatic [safety plan implementation]). Facility policy did not allow for the use of restraint for reasons other than crisis intervention or medical/dental procedures. The facility had not developed medical desensitization plans for all individuals who required the use of restraint for routine medical care. According to a list provided to the monitoring team, desensitization programs had been developed for five individuals who needed pretreatment sedation or restraint to have routine dental care completed. A sample of five plans that had been implemented was submitted to the monitoring team for review. • Four of the plans in the sample were identical and did not include individualized strategies. • The fifth plan was identified as a behavioral rehearsal plan. It included strategies to rehearse steps taken prior to actual dental work being completed. The facility maintained a "Do Not Restrain" list. There were 12 individuals at the facility that had been identified for placement on this list for which restraints would be contraindicated due to medical or physical conditions. • Individual #68 was identified on the "Do Not Restrain" with a notation of no bear hug, basket hold, or horizontal restraint. A list of all restraints in the past six months included the following for him: o 10/22/11 horizontal restraint o 10/16/11 basket hold (x2) o 10/16/11 horizontal restraint o 10/6/11 horizontal restraint o 9/12/11 horizontal restraint o 9/9/11 horizontal restraint o 8/23/11 horizontal restraint PSTs should discuss the need for restraints during medical and dental procedures, and desensitization plans should be developed that include individual specific strategies to try to reduce or eliminate the need for restraint. Teams should discuss the risks involved in restraints and ensure that support staff are trained in alternate behavioral interventions when restraints are contraindicated for individuals based on risk factors. The facility POI indicated that the facility was not in compliance with this provision. The	Noncompliance

#	Provision	Assessment of Status	Compliance
		facility was not in compliance with this provision.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Campus Shift Coordinators were the designated restraint monitors. Based on a review of 40 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 37 out of 40 incidents of restraint (93%), there was assessment by a restraint monitor. The exceptions were restraints involving Individual #116 on 7/3/11 and 5/9/11, and Individual #75 on 12/4/11. • In 29 out of 40 instances of restraint (73%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Exceptions were: o Individual #116 dated 5/19/11, 7/3/11 (x2), 7/22/11, and 12/4/11 o Individual #148 dated 11/4/11 o Individual #243 dated 8/14/11 and 10/30/11 o Individual #194 dated 7/9/11; 7/30/11; and 9/18/11. • In 29 instances (73%), the documentation showed that an assessment was completed of the application of the restraint. • In 29 instances (73%), the documentation showed that an assessment was completed of the circumstances of the restraint. Based on a review of 40 behavioral restraint records for restraints that occurred at the facility, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in 26 (65%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #116 dated 10/18/11, 8/11/11, 7/22/11, 5/19/11, and 6/24/11 o Individual #243 dated 8/14/11, 6/15/11, 6/11/11, and 6/10/11 o Individual #194 dated 7/30/11 o Individual #355 dated 11/6/11 o Individual #157 dated 11/5/11 o Individual #6 dated 11/5/11 and 11/7/11 A sample of restraint documentation for was submitted for two instances of medical restraint for Individual #38 dated 8/4/11 and 9/2/11. Both indicated that a nurse began assessing vital signs within 30 minutes of administration. Neither was assessed every 15 minutes for at least two hours as required.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility remained out of compliance with this provision. Monitoring and post restraint review should be conducted and documented as required by state policy.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample of 40 Restraint Checklists for individuals in non-medical restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 40 (100%), continuous one-to-one supervision was indicated as having been provided. • In 40 (100%), the date and time restraint was begun were indicated. • In 40 (100%), the location of the restraint was indicated. • In 14 (35%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Zero indicated what events were occurring that might have led to the behavior (see section C1 for a list of exceptions). • In 40 (100%), the specific reasons for the use of the restraint were indicated. • In 40 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 40 (100%), the names of staff who applied/administered the restraint was recorded. • In 40 (100%) of 40 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 31 (100%) of 31 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 40 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. o In four instances (10%), the nurse did not document the date of post restraint assessment for Individual #116 on 8/11/11, 7/22/11, and 6/24/11, and Individual #194 on 7/30/11. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 30 minutes in duration. In a sample of 40 records (Sample #C.1), restraint debriefing forms had been completed for 37 (93%). The exceptions were restraints involving Individual #116 on 7/3/11 and 5/9/11, and Individual #75 on 12/4/11. The facility was conducting monthly audits of restraint documentation for compliance with this provision. The facility's self assessment indicated that the facility was not in	Noncompliance

#	Provision	Assessment of Status	Compliance
		compliance with section C6. Additional staff training is needed on documenting circumstances leading up to restraints in order to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming. The facility was not yet in compliance with the requirements of this provision item.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to SGSSLC documentation, during the six-month period prior to the onsite review, a total of 25 individuals were placed in restraint more than three times in a rolling thirty-day period. This represents a decrease from the 30 Individuals placed in restraint more than three times in a rolling 30-day period reported during the last (5/11) review. Five of these individuals (i.e., Individual #153, Individual #292, Individual #346, Individual #215, and Individual #116) were reviewed (20%) to determine if the requirements of provision C7 of the Settlement Agreement were met. PBSPs, safety plans, and personal support plan addendums (PSPAs) following more than three restraints in 30 days were requested for all five individuals. A safety plan was not available for Individual #153, and PSPAs based on more than three restraints in 30 days were only available for Individual #292 and Individual #153. In order to review a larger sample of PSPAs, the monitoring team reviewed four additional PSPAs following more than three restraints in 30 days for Individual #254, Individual #85, Individual #247, and Individual #23. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. Although only one of the items below have been rated as in substantial compliance, the facility staff reported that they had recently re-trained staff to ensure that each of the issues below were discussed and documented in each PSPA meeting following more than three restraints in a 30-day period. Additionally, the facility had recently begun to collect integrity measures. The monitoring team was encouraged by these activities, and anticipates improvements in this provision item in the next review. In order to achieve substantial compliance with this item, each individual's PSPA should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Four of the six (66%) PSPA minutes reviewed did not address this issue. Two (Individual #23 and Individual #247) PSPA minutes reviewed, however, reflected a discussion of the individual's psychiatric diagnosis or psychosocial issues, and a plan to address them. For example, Individual #23's PSPA indicated that behaviors associated with her psychiatric diagnosis of borderline personality affected the target behaviors provoking restraint. The minutes suggested Dialectical Behavioral Therapy as a way to address this psychiatric issue.	
	(b) review possibly contributing environmental conditions;	All PSPAs should reflect a discussion of potential contributing environmental factors (e.g., noisy or crowded environments) and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint. None of the PSPAs reviewed reflected a discussion of possible contributing environmental factors.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item is concerned with a review of potential antecedents to the behavior that provokes restraint. None of the PSPAs reviewed addressed this issue. Examples of issues that could be discussed here would be the role of antecedent conditions such as placing demands, or the presence of novel or unfamiliar staff on the behavior that provoke restraint. This discussion should also include how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed) to decrease the future probability of the dangerous behavior.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. Possible functions of dangerous behavior that could be discussed here are escaping demands or accessing desired activities. This discussion should also include how these functions will be addressed to prevent restraints in the future. For example, if it is hypothesized that escape is maintaining physical aggression, then a discussion of how to ensure that physical aggression does not result in escape should be reflected in the PSPA minutes. One (17%) of the PSPA minutes reviewed indicated that a potential function of the behavior provoking restraint was gaining staff attention (i.e., Individual #247). No discussion, however, of how attention associated with target behaviors could be minimized (e.g., avoid eye contact, maintain flat affect) was reflected in the discussion.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Five PBSPs were reviewed. The following was found: • Five (100%) were based on the individual's strengths; • Three (60%) of the PBSPs reviewed (i.e., Individual #215, Individual #116, and Individual #292) did not specified the objectively defined behavior to be treated that led to the use of the restraint (see K9); • Five (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (the specific method for teaching the alternative behaviors, however, was not present in any of the five plans); and • Five (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. All five of PBSPs reviewed had procedures to weaken or reduce the behaviors that provoked restraint, however, one PSPA reviewed (Individual #153) was determined to be inadequate because it did not contain clear, precise interventions based on a functional assessment (see K9). The five Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In all four of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In none of the Safety Plans reviewed (0%), was the maximum duration of restraint authorized specified; • In all (100%), the designated approved restraint situation was specified; and • In all (100%), the criteria for terminating the use of the restraint were specified.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) was integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	All six (100%) of the PSPA minutes reviewed included a discussion of the effectiveness of the current PBSP (including possible modification when necessary) to decrease the future probability of requiring restraint.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
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.	There were many meetings frequently held at the facility to address restraint incidents, including Restraint Reduction Committee meetings, Incident Management Review Team Meeting (IMRT) meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Restraint incidents were also referred to the PST for follow-up. See C7 for comments on review by the PST. A sample of Face-to-Face Debriefing and Review Forms related to incidents of non-medical restraint was reviewed by the monitoring team. The review form had an area for signature indicating review by the Unit Director and the Incident Management Team. • In review of 37 restraint review forms for sign off by the Unit Director and IMC Designee, 29 (78%) were reviewed by either the Unit Director and/or the IMC Designee within three days business days of the restraint. o The restraint documentation for Individual #193 dated 11/7/11 did not include the signature page of the post restraint review form. o Restraints for Individual #116 dated 8/2/11, 7/22/11 (x2), and 7/3/11 were not reviewed within three days. o Three restraints for Individual #194 dated 7/7/11 were not reviewed until 7/15/11 by the unit director and 7/18/11 by the IMC. During the monitoring visit, the monitoring team raised some concerns over individuals who were receiving PRN psychotropic medications by request. The facility did not adhere to restraint monitoring and review requirements because these chemical sedation instances were not considered to be restraints by the facility. The facility should ensure that these instances are documented, monitored, and reviewed. Plans to reduce the use of PRN psychotropic medication should be addressed by the PST. Additional comments regarding this practice are included in section J of this report. Unit Directors were responsible for completing a review of each restraint incident. There was no indication that this review resulted in recommendations or additional staff training when warranted All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in application or documentation.	Noncompliance

Recommendations:

1. Facility administration needs to send a clear message to all staff that restraints will only be used as a last resort measure (C1).

2. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint and document all interventions attempted prior to restraint (C1).

3. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming (C1, C2, C6).

4. SPCIs should specify specific behavioral indicators to identify when release from restraint should be attempted (C2).

5. An attempt should be made to release an individual from restraint as soon as staff determines that he or she does not pose an immediate danger (C2).

6. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed to try to reduce or eliminate the need for restraint (C4).

7. Teams should discuss the risks involved in restraints and ensure that support staff are trained in alternate behavioral interventions when restraints are contraindicated for individuals based on risk factors (C4).

8. Monitoring and post restraint review should be conducted and documented as required by state policy (C5).

9. Use of PRN psychotropic medication should be monitored and reviewed following state policy requirements for restraint (C6, C8).

10. PSTs should develop reduction strategies for those individuals using PRN psychotropic medications (C1, C7, section J).

11. When restraints are not applied, monitored, or documented correctly, the restraint monitor should include this information in the follow-up assessment. Develop a plan of correction to address any deficiencies noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary (C8).

12. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation (C8).

13. Complete all of the requirements for provision item C7 (C7).

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Section D Presentation Book o SGSSLC Plan of Improvement updated 11/7/11 o DADS Policy: Incident Management #002.2,dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o SGSSLC Policy: Spurious Allegations of Abuse/Neglect/Exploitation revised 10/06/11 o MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o Information used to educate individuals and their LAR on identifying and reporting unusual incidents. o Incident Management Committee meeting minutes for each Monday of the past six months o Sample of Unit Level Meeting minutes for the past six months o Spurious Allegation PIT meeting minutes for the past six months o Human Rights Committee meeting minutes for the past six months o Three most recent five-day status reports o Training transcripts for 24 randomly selected employees o Training Curriculum: Abuse and Neglect – Identification, Reporting, and Prevention o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired in the past two months (93) o List of staff who failed to report abuse, neglect, or exploitation o Tracking log for reporters that are known to be an individual or LAR o Training and background checks for the last three employees hired o Training transcripts for facility investigators (10) o Training transcripts for DFPS investigators assigned to complete investigations at SGSSLC (15) o Abuse/Neglect/Exploitation Trend Reports FY11 o Injury Trend Reports FY11 o A list of individuals for whom DFPS conducted streamlined investigations. o List of staff against which disciplinary action had been taken due to involvement in retaliatory action. o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o Results of criminal background checks for last three volunteers o List of applicants who were terminated based on background checks o A sample of acknowledgement to self report criminal activity for 24 current employees o PSPs for Individual #321, Individual #251, Individual #120, Individual #325, Individual #336, Individual #50, Individual #294, and Individual #214 o Injury reports for three most recent incidents of peer-to-peer aggression incidents

- PSP, BSP and PSPA related to the last three incidents of peer-to-peer aggression
- List of all serious injuries for the past six months
- List of all A/N/E allegations since 5/1/11 including case disposition
- List of all investigations completed by the facility since 5/1/11
- List of all confirmed allegations of abuse and neglect
- List of employees reassigned due to ANE allegations
- A sample of completed audits summaries for abuse and neglect concerns or unusual incidents
- Client Injury Reports for the past six months for Individual #336, Individual #161, Individual 75, Individual #97, Individual #186, Individual #385, Individual #116, Individual #386, Individual #73.
- Documentation from the following completed investigations including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#39564587	Physical Abuse	Unconfirmed	5/26/11 11:16 am	5/26/11 2:56 pm	6/3/11
#40243436	Neglect	Confirmed	8/19/11 2:49 pm	8/22/11 2:40 pm	8/29/11
#40230331	Neglect (2)	Unfounded (2)	8/8/11 11:23 pm	8/11/11 3:28 pm	8/12/11
#40230383	Emotional/Verbal Abuse	Unconfirmed	8/9/11 1:42 am	8/9/11 10:30 am	8/18/11
#40241249	Physical Abuse	Unconfirmed	8/18/11 2:03 am	No AV interview	8/25/11
#40243095	Physical Abuse	Inconclusive	8/19/11 11:54 am	8/19/11 4:23 pm	8/29/11
#40250981	Emotional Verbal Abuse Neglect Physical Abuse (3)	Unconfirmed Confirmed Unconfirmed (2) Confirmed (1)	8/25/11 11:31 pm	8/26/11 2:29 pm	9/23/11 *methodological review
#40250795	Emotional Verbal Abuse (2)	Confirmed (2)	8/25/11 7:10 pm	8/26/11 3:01 pm	9/4/11
#40266365	Neglect (4)	Confirmed (1) Unconfirmed (3)	9/7/11 5:12 pm	9/8/11 10:19 am	9/29/11
#30254730	Emotional Verbal Abuse Physical Abuse Sexual Abuse	Unconfirmed	8/28/11 2:21 pm	8/28/11 6:32 pm	9/7/11

#40278765	Physical Abuse (5)	Confirmed (5)	9/18/11 2:26 am	9/18/11 2:01 pm	9/28/11
#40286541	Physical Abuse (3)	Confirmed (3)	9/23/11 9:10 pm	9/26/11 12:56 pm	10/3/11
#40287204	Neglect (2)	Inconclusive (1) Unconfirmed (1)	9/24/11 9:42 pm	9/27/11 3:57 pm	10/4/11
#40295801	Emotional/Verbal Abuse (2) Physical Abuse (2)	Unconfirmed	10/2/11 3:00 pm	10/2/11 5:46 pm	10/10/11
#40300269	Emotional/Verbal Abuse	Unconfirmed	10/6/11 1:15 am	10/7/11 1:40 pm	10/20/11
#40236948	Emotional/Verbal Abuse (3)	Unconfirmed	8/14/11 8:13 pm	8/17/11 2:16 pm	8/22/11
#40381576	Neglect (3)	Confirmed (1) Unconfirmed (2)	10/22/11 9:11 pm	10/23/11 3:40 pm	11/10/11
#40392118	Emotional/Verbal Abuse Physical Abuse	Confirmed Confirmed	10/24/11 1:00 pm	10/25/11 10:50 am	11/11/11
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**	**Began Investigation**	**Closed Investigation**
#40257046	Neglect	Referred Back	8/30/11 1:28 pm	8/30/11 3:45 pm	9/14/11
#40270321	Physical Abuse (4)	Unconfirmed (4) Referred Back	9/11/11 12:12 am	9/11/11 3:05 pm	10/5/11
#40270443	Emotional/Verbal Abuse (1) Physical Abuse (2)	Unconfirmed Unconfirmed (1) Referred Back(1)	9/11/11 8:58 am	9/11/11 3:37 pm	11/7/11
#40305672	Physical Abuse	Referred Back	10/11/11 10:58 am	Unknown	11/4/11
#40300739	Neglect	Referred Back Clinical Issue	10/6/11 11:42 am	Unknown	10/13/11
#40396356	Neglect	Referred Back	10/24/11 8:50 pm	Unknown	10/27/11
#40386076	Neglect	Referred Back	10/23/11 5:58 pm	Unknown	10/25/11
#40436717	Neglect	Referred Back Clinical Issue	10/28/11 1:34 pm	Unknown	11/4/11

Sample D.3	Type of Incident	Date/Time of Incident	Director Notification		
#4462	Sexual Incident	9/2/11 11:25 am	Unknown		
#4513	Sexual Incident	9/22/11 12:56 pm	9/22/11 1:20 pm		
#76	Sexual Incident	9/30/11 8:30 am	9/30/11 9:30 am		
#82	Serious Injury	10/3/11 7:42 am	10/3/11 8:20 am		
#90	Serious Injury	10/5/11 12:20 pm	10/5/11 1:08 pm		
#110	Serious Injury	10/12/11 6:30 am	10/13/11 8:05 am		
#4587	Sexual Incident	10/24/11 8:00 pm	10/24/11 8:11 pm		
#4604	Sexual Incident	11/2/11 9:17 am	11/2/11 3:00 pm		

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Jawlown McCleery, Incident Management Coordinator
- Mary Holmes, Facility Investigator
- Michael Davila, QDDP Coordinator
- Roy Smith, Rights Protection Officer
- Zula White, Rights Protection Officer Assistant
- Gary Flores, Director of Day Services
- Michael Fletcher, QDDP Educator
- John Church, POI Coordinator
- Robb Weiss, Chief Psychologist
- Noel Zapata, Vocational Services Director

Observations Conducted:

- Observations at residences and day programs
- Unit 1 Morning Meeting – 12/6/11
- Incident Management Review Team Meeting 12/6/11 and 12/7/11
- Human Rights Committee Meeting 12/7/11
- Restraint Reduction Committee 12/8/11
- Annual PSP meetings for Individual #285

	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. The facility's POI for section D indicated that several new processes had been implemented to address deficiencies noted in the last monitoring report. The POI indicated that the facility had implemented a new audit/self assessment system to address compliance with section D. The POI indicated that the findings from this new audit process were used to determine the self-rating of most of the provision items. The facility POI indicated that SGSSLC was in substantial compliance with all sections D of the Settlement Agreement. The monitoring team found that 13 out of 22 areas of section D were in substantial compliance. As discussed below, the monitoring did not find evidence to support substantial compliance with provisions D1, D2a, D2b, D2e, D2i, D3g, D3i, D4, and D5. The facility POI noted processes that were in place to address provisions, but many of the processes were newly implemented and had not yet had an impact on the cases reviewed in the sample. Effective monitoring was not in place to determine if the processes were ensuring compliance. For example, the facility POI noted that QDDPs were recently trained to document sharing information with individuals and LARs regarding identifying and reporting abuse and neglect. PSPs dated after training was provided still did not include evidence of compliance with this provision. The facility was in the process of developing a quality improvement process to address issues identified through the self audit system. The facility was holding daily meetings to review all incidents and injuries. It was not evident that the facility had a process in place to look at systemic issues contributing to incidents and injuries. The facility will need to implement a process to address incident and injury trends.
	Summary of Monitor's Assessment: According to information provided to the monitoring team, DFPS confirmed 17 allegations of abuse [verbal or physical] and 22 allegations of neglect at the facility. There were a total of 694 allegations of abuse, neglect, or exploitation that were investigated by DFPS at the facility from 5/1/11 through 9/30/11. In addition to the 39 (6%) confirmations, 480 (69%) were unconfirmed allegations, 36 (5%) were inconclusive, 35 (5%) were unfounded allegations, and 104 (15%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect. This was an increase of 16% in the number of allegations reported in the prior five months. A list of all serious incidents investigated by the facility during the previous six months was requested by the monitoring team. The facility provided a summary of incidents from 5/1/11 through 9/30/11. In this five month period, there were an additional 37 serious incidents at the facility that did not involve allegations of abuse or neglect investigated by the facility.

Incident Type	Total
Encounter with law enforcement	2
Serious Injury	15
Sexual Incident	10
Choking	2
Unauthorized Departure	6
Death	2
Suicide Threat	2

There were a total of 1735 injuries reported between 5/1/11 and 11/31/11. These 1735 injuries included 24 serious injuries resulting in fractures or sutures. It was not evident that the facility was adequately addressing the high number of injuries documented at the facility with preventative actions. Documentation indicated that a significant number of injuries were resulting from behavioral issues, including peer-to-peer aggression.

The facility had taken a number of steps to address concerns related to incident management at the facility. Action was primarily targeted toward reporting and documentation of incidents rather than reduction and prevention of incidents. Some positive steps taken to address the provisions of section D included:

- An audit process was implemented to test staff knowledge of steps for reporting incidents.
- The DADS Section D Monitoring Tool was implemented.
- A tracking method was established for identifying staff who failed to report ANE.
- QDDPs were trained on revised process for documentation of educating individuals and their LARs on identifying and reporting ANE.
- A flowchart was developed for reporting unknown injury investigations.
- A complaint line was established for individuals to report complaints regarding services at the facility.
- The facility began using the new state office Avatar system for documenting investigations.
- The Incident Management Director began presenting DFPS final reports to the Incident Management Committee for review.
- Additional positions were approved for the incident management department.

The facility Incident Management Coordinator and facility investigators were knowledgeable and fastidious in regards to ensuring investigations were completed when incidents occurred at the facility. The facility had a relatively small incident management department when considering that there were, on average, over 100 incidents and allegations per month to be investigated and only two full time investigators. Although, a number of steps had been taken to ensure incidents and injuries were appropriately investigated and corrective action was documented, there had not been a focused effort on addressing systemic issues that placed individuals at risk for abuse, neglect, and injury.

The facility needs to further explore trends of incidents and injuries and develop a plan of action to address

	any trends identified in order to reduce the significant number of confirmed allegations and injuries occurring at the facility. Consideration should be given to factors that generally contribute to injuries and incidents at a large facility, such as design of living areas, levels of supervision, training of staff, and availability of meaningful activities. The incident management department cannot be held exclusively accountable for compliance with the requirements of section D. As the facility moves forward, all departments will need to take an integrated, aggressive approach to restructuring the environment, supports, and programming to address these issues. It remains a concern of the monitoring team that individuals at the facility are at high risk for harm in their current environment.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the Director or designee. In practice, the facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: • There were posters regarding this mandate posted throughout the facility with both information on identifying abuse and neglect and steps to be taken if abuse or neglect was either suspected or witnessed. • Employees at SGSSLC were required to sign a form titled Acknowledgement of Responsibility for Reporting Abuse/Neglect Incident(s) form during pre-service training and every 12 months thereafter. Completed forms were requested by the monitoring team for a random sample of 24 employees. All (100%) had signed a form acknowledging responsibility to report abuse and neglect within the past 12 months. Additionally, signed forms were provided for all employees hired within the past two months. The facility provided a copy of the signed acknowledgement for 93 new employees. • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 24 current employees at the facility were reviewed for current ABU0100 training. Of these, 24 (100%) had completed the course ABU0100 in the past 12 months.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The facility had implemented an audit system that included a random sample of interviews with employees regarding reporting procedures for allegations of abuse, neglect, and exploitation. Sixty-seven interviews were conducted in the quarter prior to the monitoring visit with compliance ratings for each month ranging from 96% to 98%. • Thirteen employees were terminated between June 2011 and December 2011 related to confirmed allegations of Abuse, Neglect, or Exploitation. Documentation of disciplinary action was reviewed for six cases in which DFPS substantiated an allegation of abuse or neglect and the AP was known. • In four cases, the AP(s) were dismissed following the confirmed allegation. In three cases, the employee reassignment log indicated that the AP was allowed to return to work, and then dismissed at a later date (DFPS cases #40243436, #40250981, and #40278765). • In DFPS case #40392118, the AP resigned following confirmed allegations of physical and emotional/verbal abuse. • In DFPS case #40250795, confirmed allegations of emotional/verbal abuse were returned against two employees for taunting an individual and calling him a derogatory name. Both employees were suspended without pay for five days and required to attend training on Appropriate Interactions and Communications. o The facility needs to consider in cases, such as this one, where abuse was so intentionally cruel and malicious whether allowing an employee to retain his or her job is sending a clear message to all employees that the facility values the individuals who are living there and will not tolerate any form of intentional abuse as is implied in the term "zero tolerance." The facility found evidence that there were eight known instances where employees had not reported suspected abuse and/or neglect as required by policy from 7/26/11 through 11/2/11. All employees involved were required to complete a refresher course in reporting abuse and neglect. The number of known instances where employees failed to appropriately report abuse or neglect in this short period of time raised some concerns over whether or not suspected abuse or neglect routinely goes unreported. The facility continued to have a high number of confirmed allegations of abuse and neglect. While it was noted that the facility consistently investigated allegations and took disciplinary action when needed, there needs to be a greater focus on determining how to prevent abuse and neglect at the facility. The facility needs to look at practices that may contribute to incidents of abuse and neglect and take an aggressive approach to	

#	Provision	Assessment of Status	Compliance
		reducing the risk. This may need to include: • Better screening of job applicants, • Revised training procedures, • Ensuring that "pulled" staff are adequately trained and supported, • Looking at ways to reduce staff stress, • Ensuring staff have the knowledge and support that they need to deal with behavioral issues, • Recognizing employees with exemplary work skills, • Increased on the job supervision and monitoring, and/or • Examining staffing ratios and the assignment of responsibilities. The facility was not found to be in substantial compliance with this provision	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation, • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats • Theft by staff, and • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	standardized reporting.	The facility policy titled Client Injury Reports and Injuries of Unknown Source Reports revised 11/03/11 did not include guidelines for reporting or documenting serious injuries that were consistent with requirements of the state policy on Incident Management or the requirements of the Settlement Agreement. The facility policy only mandated that certain serious injuries were to be reported to the facility director/designee and allowed 24 hours for the notification to occur. The facility policy did not require the DADS UIR to be completed on each serious injury. According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 694 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 694 allegations, there were: • 508 allegations of abuse [verbal or physical], o 17 were substantiated, o 405 were unsubstantiated, o 23 were inconclusive, o 36 were referred back to the facility for investigation, and o 27 were unfounded. • 8 allegation of exploitation, o 7 were unsubstantiated, and o 1 was referred back to the facility for investigation. • 178 allegations of neglect, o 22 were substantiated, o 68 were unsubstantiated, o 13 were inconclusive, o 67 were referred back to the facility for investigation, and o 8 were unfounded. According to a list provided to the monitoring team, the facility investigators conducted investigations for 37 additional serious incidents since the previous monitoring visit. From investigations since 5/1/11 reported by the facility, 34 investigations were selected for review. The 34 comprised three samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample. • Sample #D.2 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation. • Sample #D.3 included investigations the facility completed related to serious	

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		incidents not reportable to DFPS. Based on a review of the 18 investigative reports included in Sample #D.1: • 14 of 18 (78 %) reports in the sample indicated that DFPS was notified within one hour of the incident or discovery of the incident. DFPS cases #40243436 and #40266365 were included in a list of eight incidents of late reporting provided by the facility. Two additional instances of late reporting were identified: o In DFPS case #40392118, the incident reportedly occurred at 11:45 am. DFPS was notified at 1:00 pm, slightly outside of the one hour reporting period. The witness to the incident reported the incident to other staff before reporting the incident to DFPS. o In DFPS case #40241249, an individual was seen by an RN for an injury and reported an allegation of physical abuse to the RN at 12:15 am. The allegation was not reported to DFPS until 2:03 am. • Eighteen (100%) indicated, the facility director or designee was notified within one hour by DFPS. • 13 of 14 (93%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. The exception was DPPS case #40286541 regarding an allegation of physical abuse. • Eighteen (100%) indicated that the state office was notified as required. In reviewing Sample D.3 (serious incidents), documentation indicated: • Five of eight (63%) were reported immediately (within one hour) to the facility director/designee. The UIR did not indicate that the facility director was notified within one hour in the following incidents: o UIR #4462 sexual incident o UIR #110 serious injury o UIR #4604 sexual incident • The state office was notified as required in six of eight (75%) cases. The exceptions were UIR #4462 and UIR #82. • DADS Regulatory was notified the four of five (80%) cases when required. The exception was UIR #4462. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR which contained information about notifications was included in: • 18 out of 18 (100%) investigation files in Sample #D.1. • 16 of 16 (100%) investigation files in Sample #D.2 and Sample #D.3.	

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		An additional sample of client injury reports was reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. This included injury reports for Individual #336 dated 8/30/11, Individual #161 dated 7/7/11/11, Individual #75 dated 7/8/11, Individual #7 dated 9/9/11, Individual #186 dated 9/19/11/11, Individual #385 dated 8/18/11 and 9/6/11, Individual #116 dated 8/22/11, and Individual #73 dated 8/15/11. • According to a list of all investigations completed by the facility, all serious injuries had been investigated. • According to the facility Client Injury Report, the Facility Director/Designee was notified within one hour in six out of nine (67%) of the serious injuries. He was not notified within one hour for the following incidents: o Individual #73 dated 8/15/11 o Individual #385 dated 9/6/11 o Individual #186 dated 9/19/11 New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was requested for 93 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form. Based on an interview of eight staff responsible for the provision of supports to individuals, seven (88%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. One staff person stated that he would report suspected abuse or neglect to his supervisor. As noted in D1, the facility provided a list of eight known instances where employees had not reported suspected abuse and/or neglect as required by policy from 7/26/11 through 11/2/11. All employees involved were required to complete a refresher course in reporting abuse and neglect. The facility was not in substantial compliance with the reporting requirements of this provision.	
	(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	The facility had a system in place for assuring that alleged perpetrators were removed from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of 18 investigation reports included in Sample D.1, in every instance	Substantial Compliance

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	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.	where an alleged perpetrator (AP) was known, the AP was immediately placed in no contact status. The monitoring team was provided with a log of employees who had been reassigned since 5/1/11. The log included the applicable investigation case number, the date of the incident and the date the employee was returned to work if the employee or in some cases discharged. It was not clear in all cases that when retraining or termination was recommended that it occurred prior to the employee returning to his or her previous position. In 15 out of 15 cases (100%) where the AP was known, the employee was not returned to client contact prior to the completion of the investigation or when the employee posed no risk to individuals. The facility had a list of 12 individuals that had been placed on the list for DFPS streamlined investigations. The facility policy titled Spurious Allegations of Abuse/Neglect/Exploitation required that immediate protections were to include removing the alleged perpetrator by placing him/her on Non-Client Contact (NCC) until the preliminary investigation of the allegation was completed. Following the preliminary investigation, the policy noted that protections may be changed by the director/designee to monitoring of the employee returned to duty. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 34 investigation files in Sample D.1, D.2, and D.3, 34 of 34 documented additional protections implemented following the incident, including medical assessment, emotional assessment, changes in level of supervision, changes in level of supervision, or removal of the AP from direct client contact. The standardized UIR form had recently been revised by the state office. Investigations completed after August 2011 were completed using the new UIR format. Description of corrective actions taken was much more detailed on these latest reports. The facility should document when or if an employee was returned to his or her position. Employees should complete all recommended retraining prior to being released to work.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 17 (100%) of 17 employees (employed over one year) with current training	Substantial Compliance

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		completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 11 (65%) of the 17 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with eight direct support staff in various homes and day programs: • Seven (88%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. One staff reported that he would tell his supervisor if he suspected abuse or neglect. The following procedures had been put into place to ensure all staff received timely training on recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. • All staff were required to sign an acknowledgement form stating that failure to complete refresher training as required could result in disciplinary action. • A list of employees with training due or delinquent was sent to each department head monthly. • Any staff member failing to attend or successfully complete training was allowed to continue working, but was not eligible for overtime. The facility had begun using a monitoring system that included a short verbal quiz for employees regarding the procedures for reporting abuse and neglect. The monitoring team rated the facility in substantial compliance with this provision based on the implementation of a system to ensure training was completed in a timely manner.	
	(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	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter. A sample of this form was requested for 93 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form. The facility's self assessment indicated that a sample of 83 employee records had been reviewed for evidence of a current signed Acknowledgement of Employee Responsibility for Reporting Abuse/Neglect Incidents. All employees (100%) reviewed had signed the form.	Substantial Compliance

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	Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. A sample of 18 DPFS reports included six examples where employees failed to report abuse. The failure to report was addressed in five (83%) of six cases. • In DFPS case #40243436, three employees were required to complete refresher training for failing to report neglect. • In DFPS case #40266365, two employees were required to complete refresher training for failing to report neglect. • In DFPS case #40241249, an individual reported abuse to a facility nurse. The nurse did not immediately report the allegation. No recommendations were made and no disciplinary action was taken to address the issue. The facility was in substantial compliance with this item. In order to send a clear message to all employees that abuse and neglect will not be tolerated, the facility needs to ensure that all incidents of failing to report by employees is addressed and that corrective action is immediate and appropriate.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. The guide was a clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. The monitoring team noted that the facility did not include documentation that information on reporting abuse and neglect had been shared with individuals and their LARs during the last review. The facility POI indicated that steps had been taken to correct this deficiency. • A prompt was added to the PSP guide to include documentation of the discussion related to ANE Resource Guide information. • QDDPs were retrained on the process of including this information in PSPs on 8/15/11. A sample of 10 PSPs developed after 9/1/11 was reviewed for compliance with this provision item. The sample included PSPs for Individual #321, Individual #251, Individual #120, Individual #325, Individual #248, Individual #39, Individual #336, Individual #50, Individual #294, and Individual #214	Noncompliance

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		• Five (50%) documented that this information was shared with individuals and/or their LARs at the annual PST meetings. In informal interviews with individuals during the review week, all individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. There were at least two examples in the sample of individuals reporting abuse or neglect directly to DFPS. The facility provided a list of 40 investigations since 6/1/11 where the individual or LAR reported an allegation of abuse or neglect to DFPS. The facility remained out of compliance with this item. QDDPs continue to need to be reminded to include documentation in PSPs regarding the sharing of information on recognizing and reporting abuse, neglect, and exploitation.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights, • information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a rights protection officer at the facility. Information was posted around campus identifying the rights officer with his name, picture, and contact information. The rights officer was known by individuals at the facility and was actively involved in meetings regarding abuse, neglect, and rights issues. Home managers were required to complete a checklist each month that was submitted to the unit director. The checklist included an item to ensure that posters on exercising rights and rights violations were visible in each home. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of 18 allegation investigations completed by DFPS (Sample #D.1),	Substantial Compliance

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		DFPS had notified law enforcement and OIG of the allegation in 13 of 14 (93%) when appropriate. The exception was DPPS case #40286541 regarding an allegation of physical abuse. Not all allegations referred were necessarily reportable to OIG. OIG completed investigations in six of the cases referred. The facility had a process in place to verify that law enforcement had been notified when appropriate. Facility UIRs documented notification to law enforcement and the outcome of the investigation if an investigation was completed by OIG. The facility was in substantial compliance with this item.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • SGSSLC policy addressed this mandate. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this it occurred. The facility was asked for a list of staff who alleged that they had been retaliated against for, in good faith, reporting an allegation of abuse/neglect/exploitation. One name was provided. Details of the incident were not provided. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation for reporting. It was evident based on the sample reviewed; staff routinely report incidents when abuse or neglect was suspected. The facility self assessment indicated 100% compliance with this provision. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	Substantial compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to the facility POI, the following measures had been implemented to address this provision. • The facility audit process of serious injury investigations had been formalized. • Incident management staff were trained on the facility process. • An audit tool was created to appropriately identify reports of significant resident injuries and whether the injury was reported for investigation. Sample #D.3 included investigations completed on a sample of serious injuries. All three (100%) of the investigations were thorough and completed using a standardized UIR.	Noncompliance

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		Appropriate recommendations were made for follow-up action in each case. As noted in D2a, an additional sample of serious client injury reports was reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. According to a list of all investigations completed by the facility, all serious injuries in the sample had been investigated. A sample of non-serious discovered injuries was reviewed for injuries or trends that should have been identified for investigation. This sample included injury reports for Individual #386, Individual #385, Individual #186, Individual #75, Individual #73, Individual #336, and Individual #97. • For Individual #97, CIRs were completed for 13 incidents involving discovered bruises. On 7/13/11 staff discovered scratches on his knuckles and bruising to both biceps. The injury was investigated and resulted in confirmed allegations of neglect and abuse. Additional CIRs were completed on 7/17/11, 8/28/11, 8/31/11, 9/3/11, and 10/10/11. All documented similar discovered injuries, but were not referred for investigation. • Individual #386 had a CIR dated 7/4/11 that was attributed to alleged employee aggression. Witness statements attached to the CIR did not reveal a probable cause for the injury. No further investigation was evident. • CIRs were completed for Individual #73 on 7/30/11, 9/27/11, and 10/21/11. All three incidents involved discovered bruises on her arm and breasts. Two of the three incidents were investigated. The incident on 9/27/11 was not investigated. Semi-annual audits of injuries should assure that all serious injuries are reported for investigation and that non-serious injuries that raise a suspicion of abuse either due to the nature of the injury or frequency of injury are investigated. Additionally, trends of similar injuries should be investigated in order to develop protections to reduce the likelihood of further injury. Based on the sample of documentation reviewed, the facility's audit process was not adequate for ensuring that injuries or trends of injuries were reported for investigation.	
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		

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	investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on conducting investigations and working with people with developmental disabilities. Thirteen DFPS investigators were assigned to complete investigations at SGSSLC. The training records for DFPS investigators were reviewed with the following results: • Thirteen investigators (100%) had completed the requirements for investigations training. • Thirteen DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SGSSLC had 10 employees designated to complete investigations. The training records for those designated to complete investigations were reviewed with the following results: • 10 (199%) facility investigators had completed CIT0100 Comprehensive Investigator Training or CSI 0100 Conducting Serious Incident Investigations. • 10 (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Eight (80%) had completed Root Cause Analysis according to training transcripts reviewed; and • 10 (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Additionally, facility investigators did not have supervisory duties; therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility was in substantial compliance with this provision.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. One of 18 (6%) investigations reviewed indicated that a facility employee had not cooperated with investigators. The facility provided a list of employees failing to cooperate with DFPS investigators. There were two additional instances included that were not in the sample reviewed. • In DFPS case #40266365, an allegation of neglect was confirmed after an	Substantial Compliance

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		individual was found with a razor blade in his mouth due to a breach in supervision. One of the employees was dishonest in her interview with DFPS regarding the case. The employee had previously been reprimanded and retrained for poor work performance at least once in each of the previous three months. She was given one paid day off work to "make a decision about your job performance and continued employment." • In DFPS cases #40270694 and #40300269, recommendations were made for disciplinary action to address the lack of cooperation by employees with DFPS investigators. For a majority of the cases reviewed, employees cooperated with all entities conducting investigations. The facility was in substantial compliance.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 18 investigations completed by DFPS (Sample #D.1), 13 had been referred to law enforcement agencies. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • OIG completed investigations in six of the referred cases and found evidence of criminal activity in one case in the sample. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility POI indicated that quarterly meetings continued to be held with DFPS and OIG to discuss any new procedures or problems with investigations. The facility was found to be in substantial compliance with this provision.	Substantial Compliance

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	(d) Provide for the safeguarding of evidence.	The SGSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.3): • There was no indication that evidence was not safeguarded during any of the investigations. The facility remained in substantial compliance with this item.	Substantial compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DFPS had implemented a new commencement policy effective 8/1/11. Mandates in the new policy were described in the MH & MR Investigations Handbook published on 10/1/11. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations noted the date and time of initial contact with the alleged victim. This contact did not occur within 24 hours in seven of 18 (39%) investigations. Seventeen investigations indicated that some type of investigative activity took place within the first 24 hours. For the seven where initial contact was not made with the alleged victim, this included gathering other documentary evidence and making initial contact with the facility. Although this meets DFPS guidelines for investigation commencement, an immediate interview with the alleged victim is the best way to ensure that the individual is able to relay accurate information to aid in the investigation. o In Investigation #40286541, the investigator failed to initiate the investigation within 24 hours. This case involved three allegations of physical abuse. The abuse was confirmed. • Thirteen of 18 (72%) were completed within 10 calendar days of the incident. o An extension was filed in all five cases not completed within 10 calendar days. • All 10 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis	Substantial Compliance

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		for the investigation findings are discussed below in section D3f. • In five of the 18 DFPS investigations reviewed (28%), concerns or recommendations for corrective action were included. Concerns were appropriate based on evidence gathered during the investigation in all five cases. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3: • 8 of 8 (100%) of the UIRs reviewed indicated when the investigation commenced. All investigations in the sample commenced within 24 hours of the incident. • 8 of 8 (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • All eight investigations included recommendations for corrective action (100%). The adequacy of these recommendations is discussed further in D2i. The facility was found to be in substantial compliance with investigation commencement and conclusion timelines. DFPS needs to ensure that initial contact with the alleged victim is conducted as soon as possible to prevent the loss in critical evidence in the case.	
	(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	SGSSLC Incident Management Policy required a UIR to be completed for each serious incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following: o In 18 (100%), each serious incident or allegations of wrongdoing; o In 18 (100%), the name(s) of all witnesses; o In 18 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 18 (100%), the names of all persons interviewed during the investigation; o In 18 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of	Substantial Compliance

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	questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	questions posed, and a summary of material statements made; o In 18 (100%), all documents reviewed during the investigation; o In 18 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS investigations now included a statement indicating that previous investigations were reviewed and either found relevant or not relevant to the case. o In 18 (100%), the investigator's findings; and o In 18 (100%), the investigator's reasons for his/her conclusions. For one investigation in the sample, contents of the report of the investigation of a serious incident were not sufficient to provide a clear basis for its conclusion: • In DFPS investigation #40241249, the alleged victim (AV) reported that a staff member slapped her in the face. According to the injury report, her cheek was swollen. The investigator did not interview the AV because according to her psychologist, an interview would reinforce her attention seeking behavior. The investigator concluded that the abuse did not occur based on lack of witnesses or video evidence. It is a concern that individuals at the facility with a history of spurious reporting or self injurious behavior might not be allowed to speak to an investigator when evidence suggests that an injury did occur that was not witnessed. <u>Facility Investigations</u> The following summarizes the results of the review of six facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In eight (100%), each serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of all alleged victims and perpetrators when known; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (100 %), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In eight (100%), all documents reviewed during the investigation; o In eight (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. o In eight (100%), the investigator's findings; and	

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		o In eight (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. According to the facility POI, several action steps had been implemented since 8/1/11 to address review of investigations. • The format of Incident Management Committee meeting notes were revised to include a column for the date that DFPS final reports were reviewed. • The Incident Management Coordinator was now presenting DFPS final reports in the Incident Management Committee meetings for review. • The date of review was now included on an investigation cover sheet. • A recommendation tracking guide was implemented and facility staff were trained on it. As evidenced below, review of completed investigations by the IMC and facility director were still not occurring in a timely manner. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 18 DFPS investigations included in Sample #D.1: • In 18 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. • UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Samples #D.1 and #D.2, 26 (100%) DFPS investigations were reviewed by the facility director and IMC following completion. o Only four (22%) UIRs from Sample #D.1 were signed off on by the facility director and IMC within five days of receipt of the completed investigation from DFPS. This included #39564587, #40254730, #40381576, and #40392118. o A methodological review was requested for one investigation in the sample following review of the completed report. For DFPS Case #40250981, the investigation was originally completed on 9/2/11. Documentation indicated that the review and follow-up action were not	Noncompliance

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		completed promptly. The facility director did not request a methodological review of the case until 9/19/11. DFPS completed the methodological review on 9/23/11. The IMC and facility director did not review and approve the final investigation until 10/14/11. o For Sample #D.2, five of eight (63%) documented prompt review and approval of the investigation following the facility completion date. However, two of those five investigations by the facility were not completed in a timely manner resulting in a late review and approval of DFPS investigations in 63% of the cases in the sample. This information is illustrated in the chart below.	

Investigation number and DFPS intake date	DFPS referral date	Facility Investigation completed	IMC review and approval	Director review and approval
#40257046 8/30/11	9/1/11	9/14/11	9/15/11	9/15/11
#40270321 9/11/11	9/12/11 9/14/11	10/5/11	No date given on UIR	No date given on UIR
#40270903 9/11/11	9/12/11	11/7/11	11/8/11	11/7/11
#40305672 10/11/11	10/17/11	11/4/11	11/4/11	11/4/11
#40300739 10/6/11	10/7/11	10/13/11	10/14/11	10/14/11
#40396356 10/24/11	10/25/11	10/27/11	No date given on UIR	No date given on UIR
#40386076 10/23/11	10/25/11	10/26/11	10/27/11	10/27/11
#40436717 10/28/11	10/28/11	10/31/11	10/9/11	10/9/11

Two IMRT meetings were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. These meetings were led by the facility director and attended by the IMC.

Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility.

<u>Facility Investigations</u>

- In eight of eight (100%) UIRs from sample #D.2 and #D.3 reviewed for investigations completed by the facility, the form indicated that the facility

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		director and IMC had reviewed the investigative report upon completion. • Seven of eight (86%) reviews were completed within five days of the completion date. The exception was UIR #82. Investigation documentation should indicate that all DFPS investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent. The facility was not in substantial compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for each unusual incident in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form. Evidence of follow-up to recommendations was included in the investigation file.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in a sample of 34 investigations. The facility had improved tracking procedures for the follow-up to recommendations in investigative reports. Seven investigations in Sample D.1 included confirmed allegations of abuse or neglect. All (100%) included documentation of disciplinary action taken in regards to confirmed allegations. Other investigation included recommendations for retraining of staff when warranted. • For DFPS Case #40250981, the investigation completed on 9/23/11. Two employees involved in the case were dismissed. Four employees were to complete retraining on restraint implementation and reporting procedures. One employee showed up for the scheduled retraining on 10/10/11. Documentation did not indicate that the other three employees had completed training as recommended. Examples found where programmatic action was not adequate included: • In DFPS case #40230383, the facility UIR included a recommendation that the PST meet to discuss the incident. The investigation was completed on 8/18/11. The PST did not meet to follow-up on the incident until 9/30/11. • DFPS case #40257046 was referred back to the facility because it did not meet the DFPS definition of neglect. Evidence showed that Individual #38 was left in his room in his wheelchair for at least four hours while he continued to yell and try to get staff attention. The facility addressed the fact that 15 minute well being checks were not carried out as required in his plan by retraining staff on level of supervision requirements. The follow-up training did not address lack of	Noncompliance

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		engagement or attention to his needs. Witnesses reported that he continued to yell out for assistance for at least four hours. Neither was noted to be a concern by the facility investigator. • UIR #4513 was an investigation of a sexual incident between two individuals residing at the facility. There was no indication that the PST met to discuss the incident. Concerns and recommendations did not address the need for follow-up STD testing. • In DFPS case #40305672, an administrative issue regarding peer to peer aggression was referred back to the facility for further investigation. The UIR did not document further review of this issue by the facility. The facility needs to ensure that appropriate follow-up action is recommended, completed and documented. The facility was not in substantial compliance with this item.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The team agreed with this facility's self assessment rating of substantial compliance with this item.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had a system in place to collect data on unusual incidents and investigations. Data were compiled in a numerous logs requested by the monitoring team that included: • Type of incident, • Staff involved in the incident, • Individuals directly involved, • Location of incident, • Date and time of incident, • Cause(s) of incident, and • Outcome of investigation. The latest trend reports available at the time of the review in December 2011 were for the month of August 2011. The facility was unable to review data in a timely manner to ensure that trends were addressed expeditiously because data were not compiled on a monthly basis. Data provided to the monitoring team were not consistent in the numbers of incidents reported in trend reports. The facility provided a list of totals for all types of incidents to the monitoring team. This was not consistent with totals for	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>various types of incidents appearing in the facility trend reports.

<table>
<tr><th>Incident Type</th><th>Data presented to monitoring team (Document III.17)</th><th>FYI Quarterly Trend Report October 2011</th></tr>
<tr><td>DFPS Allegations</td><td>694</td><td>341</td></tr>
<tr><td>Serious Injuries-Determined Cause</td><td>13</td><td>1</td></tr>
<tr><td>Unauthorized Departure</td><td>6</td><td>0</td></tr>
<tr><td>Sexual Incident</td><td>10</td><td>10</td></tr>
</table>

Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. There continued to be a high number of incidents and injuries at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress and take action to reduce the number of incidents and injuries.

The facility was not in substantial compliance with this provision item.</td><td></td></tr>
<tr><td>D5</td><td>Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation</td><td>By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment:
• Criminal background check through the Texas Department of Public Safety (for Texas offenses)
• An FBI fingerprint check (for offenses outside of Texas)
• Employee Misconduct Registry check
• Nurse Aide Registry Check
• Client Abuse and Neglect Reporting System
• Drug Testing

Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks.

In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. The information obtained about volunteers was</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	also reviewed. Background checks were conducted on new employees prior to orientation and completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. According to information provided to the monitoring team, for FYI 11, criminal background checks were submitted for 2407 applicants. There were a total of 9 applicants who failed the background check in the hiring process and, therefore, were not hired. One employee was dismissed due to results of background checks. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self-report all criminal offenses. A sample was requested for 24 employee's acknowledgement to self-report criminal activity forms. • Signed acknowledgement forms were submitted for 8 of 24 employees (33%). The facility needs to ensure that all staff have acknowledged his or her responsibility to self-report criminal activity as required by state policy. The facility remained in substantial compliance with this provision.	

Recommendations:

1. The facility needs to look at practices that may contribute to incidents of abuse and neglect and take an aggressive approach to reducing the risk. Consideration should be given to factors that can contribute to injuries and incidents at a large facility, such as design of living areas, levels of supervision, training of staff, and meaningful engagement (D1).

2. All serious incidents should be reported to the appropriate entities within the timeframes required by state policy (D2a).

3. The facility needs to ensure that APs are not returned to direct care positions until recommendations in terms of disciplinary action and retraining have been implemented to prevent the risk of similar incidents from occurring (D2b).

4. The facility needs to ensure that all incidents of failing to report by employees are addressed and that corrective action is immediate and appropriate (D2d).

5. QDDPs should include documentation in PSPs regarding the sharing of information on recognizing and reporting abuse, neglect, and exploitation (D2e).

6. The facility needs to develop an audit process adequate for ensuring that significant injuries and trends of injuries are reported for investigation (D2i).

7. The facility needs to ensure that appropriate follow-up action is recommended, completed and documented (D3i).

8. Investigation documentation should indicate that all DFPS investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent (D3g).

9. Data collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress (D4).

10. The facility needs to ensure that all staff have acknowledged his or her responsibility to self-report criminal activity as required by state policy (D5).

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:** Documents Reviewed: o DADS policy #003: Quality Enhancement, dated 11/13/09 o DADS Draft revised policy on Quality Enhancement, undated o Organizational chart, undated o SGSSLC policy lists, dated 10/31/11 o List of typical meetings that occurred at SGSSLC, (incomplete) o SGSSLC POI, 11/22/11 o SGSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/5/11 o SGSSLC facility-specific policies, "Quality Assurance Process," dated 4/14/11, and "Quality Improvement Council," dated 10/6/10, unchanged since last onsite review o SGSSLC DADS regulatory review reports, through 10/26/11 o SGSSLC Quality Assurance Plan/matrix, 11/16/11 o Set of blank tools used by QA department staff (four) o Set of completed tools used by QA department staff o Set of completed statewide/facility self-assessment tools showing department scores and QA staff scores (for interobserver agreement determination) o SGSSLC QA Reports, monthly, May 2011 through October 2011 o SGSSLC Corrective Action Plan, tracking, 26 pages, undated o QI Council agenda and meeting minutes from June 2011 through October 2011 (11 meetings) o PIT meeting notes for mealtimes, spurious allegations, and EMPACT o QI Council handouts, and slides, from 12/6/11 meeting o Spreadsheet comparing rating of self-assessment tools to ratings from monitoring reports o Emails indicating QA director work towards developing a listing/inventory of data collected o DADS SGSSLC family satisfaction survey online summary, monthly, May 2011 through September 2011, total of 26 respondents (average of 5 per month) o Self-advocacy monthly meeting minutes, monthly May 2011 through November 2011 o Notes about other self-advocacy group activities o Home meeting agenda and notes, last two meetings, each of the homes o Independent Ombudsman's annual report, September 2011 o SGSSLC Enlightener staff newsletter, July/August 2011, September/October 2011 o SGSSLC Settlement Agreement brochure, November 2011 o SGSSLC About Us, individual's newsletter Interviews and Meetings Held: o Angela Kissko, Director of Quality Assurance o Misty Mendez, Settlement Agreement Coordinator o Leticia Williams, QA staff member

	o Dr. Philip Baugh, Facility Director o Unit Directors: Cedric Woodruff, Vicki Hinojos, Tricia Trout o Roy Smith, Human Rights Officer, and Melissa Deere, Assistant Independent Ombudsman <u>Observations Conducted</u>: o QI Council meeting, 12/6/11 o Self-advocacy meeting, 12/6/11 o Many residences, day program, and vocational program
	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. It was updated on 11/22/11. In addition, during the onsite review, the QA director reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the QA director wrote a sentence or two about what tasks were completed and/or the status of each provision item. An entry was made almost every month. Although these provided useful information, it did not describe how a self-assessment was conducted. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The QA staff self-rated the facility as being in noncompliance with all five provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI were relevant and will help the department in achieving substantial compliance. The action steps for this provision attempted to address many of the concerns of the monitoring team. The POI action steps should be updated based upon the content of this report. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: SGSSLC made continued progress towards achieving substantial compliance with the items of this provision since the last onsite review. The QA director was instrumental in the progress that the facility was making. SGSSLC had begun to develop a listing/inventory of data collected at the facility. This should be a relatively simple task and the monitoring team and QA director discussed ways of doing so. A QA plan still needed to

	be written, however, the QA matrix was in place and continued to improve. QI Council met regularly, about twice each month, since the last review. Data were presented, Settlement Agreement sections were reviewed, and PITs provided updates. There was good participation during the three hour QI Council meeting observed by the monitoring team. A QA report was completed each month. The most recent report contained a great deal of information, such as graphs, tables, and narratives. A system of managing corrective actions was developing. A 26-page listing of corrective action plans was created, though its utility and whether it met the intention of provisions E2-E5 were not clear.

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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.	SGSSLC once again made continued progress towards achieving substantial compliance. Continued improvement was evident in many of the key areas of this provision: QA data matrix list, QA data collection, QA report, QI Council, and the management of corrective actions. Much activity had occurred since the previous onsite review. <u>Policies and General QA Planning</u> This state policy, #003: Quality Enhancement, dated 11/13/09, was still being extensively revised. A draft of the new policy was disseminated a few months prior to this onsite review. Finalization, dissemination, and implementation are the next needed steps in this aspect of quality assurance statewide. Two SGSSLC facility-specific policies remained the same since the last onsite review and comments from previous monitoring reports will not be repeated here. SGSSLC will, however, need to update, delete, and/or create new facility-specific policies when the state policy is finalized. When the new state and facility-specific policies are finalized, training for senior management and department heads should occur. Below are comments from the monitoring team regarding SGSSLC's status with some of the important component steps in the development of a QA program. The monitoring team had the opportunity to discuss these at length with the QA director and the SAC. These component steps were listed in the previous monitoring report. Detail is again provided below in hopes that it will be helpful to the QA department. 1. Create a listing/inventory of all data collected at the facility that includes the following: a. Data collected by each discipline service department; this includes two categories of data: i. Data the discipline service department uses for its own service and operational purposes	Noncompliance

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		ii. Data the discipline service department collects as part of its own self-monitoring and which includes these two categories of self-monitoring tools: • Statewide self-monitoring tools • Facility-specific tools created by the facility service department, if any (e.g., PNMP monitoring, AAC device monitoring) b. Data collected by the QA department staff: i. Data they collect themselves ii. Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring c. Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, the FSPI, and any other types of data that DADS central office may determine necessary for submission to state office. Status: SGSSLC had begun to assemble this listing/inventory. To that end, the QA director met with most of the discipline department heads to try to assemble this list by adding a number of items from each department to the QA matrix. To complete this task, however, all that is needed is a simple listing. That is, the items should not be put into the QA matrix. Trying to do so made the task more difficult than it needed to be and, as a result, the QA director had not yet gotten the information she needed to create the listing/inventory. The development of this listing will take a number of months to complete. It is likely that additional items will be added to whatever list is initially developed. Once completed, an annual or semi-annual update will likely be all that will be necessary. 2. Determine which of these data are to be submitted to the QA department for tracking and trending (and to be part of the QA matrix). Status: The QA department made continued progress on this activity. The monitoring team and the QA director discussed the goal of the QA matrix, that is, that the QA matrix should indicate all the data that the QA department will track, trend, and comment upon. Separation of the matrix from the overall listing of data (item #1 immediately above) will help the QA department in making this matrix and the QA plan functional and relevant. 3. Determine which of these data are to be included in the QA report. Status: A monthly QA report was being completed. It had improved since the last onsite review (see E2 below). 4. Determine which of these data are to be presented regularly to the QI Council. QI Council should make this determination with suggestions from the service	

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		department heads as well as from the QA director. Status: The QI Council was reviewing a lot of data. The QA report indicated that some of the data were chosen by the QI Council. The next step is for QI Council to do so with the benefit of a listing of all types of facility data, the QA matrix, and specific guidance from the department heads and the QA department. 5. Create and manage corrective actions based upon the data collected and direction from the QI Council. Status: A system of managing corrective actions had improved since the last onsite review (see E2 below). QA Department Angela Kissko remained as the QA director. She was well organized and responsive to the comments made in the previous monitoring report. She was moving the facility forward in its quality assurance program and activities. The new Settlement Agreement Coordinator (SAC), Misty Mendez, worked closely with the QA director. Their collaborative efforts were also working to the benefit of the QA program at the facility. The QA director also worked closely with the director of incident management because she managed the statewide trend analysis (i.e., data regarding restraints, abuse neglect allegations, injuries, and unusual incidents). The director of incident management submitted these data, as relevant, for inclusion in the QA report. Because these data were also listed in the QA matrix, the QA director should also do her own review of the data (i.e., QA department management and review of all items in the QA matrix). The three unit directors were also involved with QA activities. They described their recent participation in monitoring activities, committee meetings, and performance improvement teams. Quality Assurance Plan The QA director had further developed the QA matrix, but did not yet have a full QA plan. A QA plan should be a description of the overall QA program at the facility. It might include a one or two page overall description of how QA is conducted at SGSSLC; a description of the comprehensive inventory listing of all data that are collected across the facility; a description of the QA matrix and how those data are managed, reviewed, trended, and analyzed by the QA department; and the overall expectation and process for data analysis and corrective action management. The QA matrix should be included in the QA plan. It can help guide the QA department (and QI Council) in understanding what data are being managed by the QA department (some of it collected by QA department staff, some of it submitted by the discipline	

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		departments at the facility). QA Activities and Indicators QA staff collected data for areas that QA was responsible for monitoring, completed statewide self-assessment tools primarily to assess interobserver agreement, and participated on various committees and in meetings. The areas that QA staff looked at were the overall environment, reducing abuse and neglect, the overall content of records, mealtimes, and the FSPI. These data were either submitted to other department directors for them to include in their reports and/or the QA report, or were managed within the QA department by the QA director. Across the facility, a great deal of time was devoted to the implementation of the statewide Settlement Agreement provision self-monitoring tools. At SGSSLC, each provision of the Settlement Agreement had a lead person (except section I which was led by a group) and a group of people assigned to complete the tools. QA staff were not part of these groups and instead completed the tools to assess interobserver agreement reliability for some of each of the tools. If there was less than 80% agreement, the provision leader resolved the difference. If the provision leader was involved, it went to QI Council for review and solution. This system appeared to be working well. Sometimes, however, the QA staff member completed his or her tool, but the department staff member assigned to complete his or her tool, did not. As a result, there were tools completed by QA staff that had no corresponding tool with which to match. At this time, these QA-collected data were not used at all. Instead, these QA-collected data should become part of the data set for that month. For instance, the data for a department's four tools for a particular month might be comprised of three done by the department staff and one done by a QA staff. There are some important next steps in the use of the statewide tools. • First, is to update the content of the statewide tools so that they are relevant and valid. Facility managers and clinicians would likely welcome the opportunity to participate in making suggestions for additions, deletions, and re-wording of items in each tool. • Second, consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. • Third, the overall process of self-assessment will need to be reviewed. When that happens, these tools will likely become one of many components of the self-assessment procedures used by each of the departments.	

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		As discussed in previous reviews, a variety of satisfaction measures are important for a comprehensive QA program. To that end, SGSSLC conducted a staff survey. More than 300 responses were received. The results were summarized at the QI Council meeting, however, it was not clear what was going to happen as a result of these findings (e.g., follow-up, actions). Similarly, family and LAR satisfaction information was collected from 26 respondents via an online system of near 70 questions. The data had not yet been summarized or analyzed. These data should be incorporated into the QA program, and follow-up should occur on any problems or complaints identified. This would be especially relevant for the last two items, which were open-ended questions. In addition, as noted in previous monitoring reports, satisfaction measures should also be obtained for (a) individuals living at SGSSLC and (b) others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. The self-advocacy committee and the weekly home meetings might provide one way to gather information related to individual's satisfaction.	
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 QA processes that were implemented at the facility. SGSSLC continued to develop the QI Council and continued its usage of Performance Improvement Teams. Overall, to meet the requirements of this provision item, SGSSLC needs to (a) analyze data regularly, and (b) act upon the findings of the analysis. <u>QA Data Management and Analysis</u> SGSSLC made continued progress in this area. As the facility moves forward, it will be important for the QA director to review all data that are managed by the QA department (i.e., all of the data on the QA matrix). These data will need to be summarized and trended, such as on a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. Indeed, the QA director was making these types of graphs for the data that were being included in the QA report at this time. Not all of these graphs need to be created by the QA department. It is possible for the facility to set an expectation for the service departments to submit their data and their graphic summaries each month. This will have to be determined at the facility level. Many, if not all, of these graphic presentations should/can appear in the QA report and be presented to QI Council. Three activities were occurring at SGSSLC that were moving the QA program towards	Noncompliance

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		substantial compliance with this provision: • Descriptive analysis: Some, but not yet all, of the provisions and items presented in the QA report included some narrative analysis of the data. As this develops, the information should not merely be descriptive, but also informative to help the reader (and the QI Council) understand the data. • The SAC was heading up a new activity, to meet with each provision section leader for about an hour each month regarding what she called benchmarks regarding the leader's completion of activities related to the Settlement Agreement for that provision. The QA director planned to participate in each of these as well. The SAC estimated 14 of these one-hour meetings would occur each month. • The QA director was regularly considering new ways of looking at the facility's data. For example, she had recently initiated a comparison of the facility's scoring of its self-assessment tools with the monitoring team's ratings. <u>QA Report</u> The QA report had improved and progressed in its quality and depth since the last onsite review. It was 100 pages long and included many graphs and tabular presentations. The QA director should talk with the consumers of the report (i.e., QI Council) about the length because, although it was many pages long, it was easy to understand and appeared to be something that could be reviewed in a reasonable amount of time (i.e., about an hour). Further, based on discussions with the monitoring team, the QA director may be able to reduce the length by combining multiple fiscal-year graphs into a single graph. The report contained a section for each provision of the Settlement Agreement as well as additional sections for other areas (e.g., staffing). Each Settlement Agreement section contained at least two graphic presentations of statewide self-assessment tool scores that were consistent across sections: a bar graph showing that month's performance, and a line graph showing a single data point for each month thereby showing month-to-month performance. This consistent style of presentation allowed the reader to easily understand these graphs. In each section of the report, in addition to these two graphs, other data were presented in a variety of formats depending upon the data and the request of QI Council. As the QA director continues to develop the QA report, she should • Work with state office to ensure she is progressing in a way consistent with the standards set and expected by state office and the soon-to-be-issued state policy on quality assurance • Include a narrative analysis for each Settlement Agreement section of the report	

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		that is informative and does more than describe the graph • Determine whether and how corrective actions/CAPs should be incorporated (or separated) from the QA report (see below). QA-Related Meetings • QI Council: The QI Council met at least twice per month since the last onsite review. The monitoring team reviewed the minutes from each meeting and attended a meeting during the week of the onsite review. The QI Council, as of the December 2011 meeting, was going to review a quarter of the Settlement Agreement provisions at each meeting rather than trying to go through all 20 every month. This made sense and was in line with what most of the other SSLCs were doing. Even so, the QA report would include all 20 provisions each month. The agenda for the meeting observed by the monitoring team included presentations by section leaders for provisions F, I, O, and P; performance improvement team presentations regarding pneumonia (very detailed and thorough), mealtimes, medication variances, and enteral feeding. Other topics were the results of a staff survey, and the current status of staffing levels. Participation from most attendees was good. • Performance Improvement Teams: PITs continued to be an important part of service provision improvement at SGSSLC. Presentation and discussion at the QI Council demonstrated that QI Council was now doing more than merely assigning the PITs, members were more actively participating in their direction. Corrective Actions SGSSLC made continued progress in the development and implementation (E2), dissemination (E3), monitoring (E4), and modifying (E5) of corrective actions and corrective action plans since the last onsite review. To address corrective actions, a listing of corrective action plans was created. At this time, it was 26 pages long and contained approximately 150 items. The items appeared to have been generated from the QA report preparations made by the department and section leaders. The chart showed the area, the plan/outcome, responsible person, projected completion date, and status. This was a very good step towards a system of creating and managing corrective actions and CAPs. To continue to move towards substantial compliance regarding corrective action plans for this provision as well as E3, E4, and E5, the QA director will need to address the following: • The QA department needs to coordinate all of the actions that are occurring at the facility regarding corrective activities. This includes the 26-page list, items in	

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		the POI action plans, and the formation/goals of PITs. o This, however, is likely to result in an even longer list of corrective actions. • It was not clear as to whether this lengthy a list was what was intended by this provision. Further, some of the items appeared to be regular ongoing activities of the department rather than items that needed a corrective action plan. • Include in the QA plan, the plan/process for dissemination, monitoring, and modifying of these corrective actions.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	SGSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	SGSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	SGSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Revise facility-specific policies after the state policy is approved and disseminated (E1).
2. Provide training to management and clinical staff on QA and on the new state and facility policies (E1).
3. Write a QA plan, the QA matrix should be included in the QA plan (E1).
4. Create a listing/inventory of all data collected at the facility (E1)
5. Determine which of these data are to be submitted to the QA department for inclusion in the QA matrix (E1).
6. Determine which of these data are to be included in the QA report and presented regularly to QI Council (E1).
7. Manage the data that are in the QA matrix (e.g., graph, trend, analyze) (E2).
8. Modify QA report so that an appropriate narrative analysis is included for all sections; ensure the report is not too lengthy for adequate review

by QI Council members (E2).

9. Use QA-collected data if there are no corresponding department-collected data (E1).
10. Along with state office guidance, determine how to best use the statewide self-monitoring tools and whether/how to update their content (E1).
11. Include range of satisfaction measures in the QA program (e.g., individuals, staff, families, and related community businesses) (E1, E2).
12. Implement and manage corrective actions as per items E2-E5 (E2-E5).

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o DADS Procedure: Personal Focus Assessment dated 9/7/11 o SGSSLC Personal Support Plan Meeting Monitoring Checklist o SGSSLC Plan of Improvement (POI) o SGSSLC Section F Presentation Book o Q Construction Facilitating for Success Skills Performance Tool o SGSSLC Action Plans and Review Process Curriculum o Section F Audits completed for June 2011 – August 2011 o Section F Audit Summary o PSP, PSP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, for the following Individuals: • Individual #336, Individual #66, Individual #251, Individual #248, Individual #193, Individual #50, Individual #116, Individual #18, Individual #385, Individual #292, Individual #265, Individual #252, Individual #132, Individual #321, Individual #325, Individual #214, Individual #294, and Individual #120 o PSP, PBSP, PSP Addendums for the following Individuals: • Individual #188, Individual #38, Individual #283, Individual #194, Individual #243, Individual #19, Individual #148, Individual #287, and Individual #254 o Admission PSPs for Individual #157 and Individual #355. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Michael Davila, QDDP Coordinator o Roy Smith, Rights Protection Officer o Zula White, Rights Protection Officer Assistant o Gary Flores, Director of Day Services o Michael Fletcher, QDDP Educator o John Church, POI Coordinator o Robb Weiss, Chief Psychologist o Noel Zapata, Vocational Services Director

	Observations Conducted: o Observations at residences and day programs o Unit 1 Morning Meeting – 12/6/11 o Incident Management Review Team Meeting 12/6/11 and 12/7/11 o Human Rights Committee Meeting 12/7/11 o Restraint Reduction Committee 12/8/11 o Annual PSP meetings for Individual #285
	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. It was updated on 9/23/11. During the onsite review, the QDDP Coordinator reviewed the presentation book for this provision. The facility reported that it was focusing on deficits noted in Section F, but acknowledged that many of these efforts were in the beginning stages. Most of the items required by this provision were not yet fully implemented. According to the POI, the facility's self-rating, determined through data collected from observations and document reviews using the statewide audit tool for Section F, SGSSLC Staff Interview/Observation tool, and the PSP monitoring tool. Three audits per month were being conducted by the Lead QDDPs, the QDDP Coordinator, and Residential Coordinator. Compliance scores from the self-audit were between 19% and 67%. Overall compliance for Section F requirements was 48%. The comments section of each item of the provision included a statement regarding what tasks had been completed or were pending and results of any audits conducted, if applicable. The POI indicated that a number of new processes had been implemented in regards to PSP development and implementation. It was too soon to evaluate the adequacy of most of these changes. The facility assigned a noncompliance rating to all items in Section F with the exception being F2f. Though progress had been made in regards to this item, the monitoring team found that not all plans were in place following development. The monitoring team agreed with all other self ratings. As noted throughout section F, while the monitoring team did see continued progress in this area with the new style PSPs, assessments were still not completed or updated as needed, key members of the team were not present at annual meetings, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.
	Summary of Monitor's Assessment: DADS had recently initiated a thorough review of the PSP process and hired a set of consultants to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. Comments are more generalized for Section F of this report in light of the fact that SGSSLC was still waiting on initial technical assistance from consultants before fully implementing the person centered planning process.

	Two of the three PSP meetings scheduled during the review week were observed by the monitoring team. In meetings observed, the QDDPs were attempting to ensure that all necessary information was covered during the PST meeting. Meetings attended were lengthy and somewhat fragmented in discussing supports. There was minimal progress being made on developing plans that would lead to a more meaningful day for individuals. PSTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want. Compliance with section F will require the facility to complete thorough assessments in a wide range of disciplines to determine what services are meaningful to each individual served and what supports are needed to allow each individual to fully and safely participate in those services. Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Quality assurance activities with regards to PSPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the PSP development process. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST. The PSPs that were reviewed were chosen from among the most recently developed PSPs. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and PSTs had been responsible for the development of the plans.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and	QDDPs were responsible for facilitating PST meetings at the facility. The QDDPs were also responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. While onsite, the monitoring team observed two of the three PSP meetings held. Both	Noncompliance

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	revising treatments, services, and supports.	meetings observed during the monitoring visit confirmed that QDDPs were facilitating PSP meetings. A sample of 12 PST attendance sheets was reviewed for presence of the QDDP at the annual PST meeting. At all annual meetings, there was a QDDP present. The annual PSP meeting for Individual #285 was held the week of the monitoring visit in a room with no heat. Team members came to the meeting bundled in coats, hats, and gloves. Some team members left before the meeting ended. While this is probably not a common occurrence, the facility needs to take into consideration all factors that inhibit the PST's ability to come together as a team for planning. All QDDPs had attended facilitation skills training. Additionally, DADS had hired a team of consultants who were providing classroom training, coaching, and mentoring to the PSTs on facilitation skills and PSP development. The consultants had not yet provided technical assistance to SGSSLC. In light of upcoming revisions to the PSP process, teams were moving slowly in making necessary changes in the structure of PSP meetings. The QDDP Coordinator reported that QDDPs were at varying stages in learning to competently facilitate meetings that encouraged integrated discussion adequate for developing appropriate supports. The QDDP Coordinator was attending a sample of PST meetings and evaluating the QDDP's facilitation skills using the Q Construction QMRP Facilitation Skills Performance Tool. He was providing feedback and mentoring as part of this assessment process. As QDDPs gain greater experience at facilitating meetings, they should be able to guide team members to hold a more in-depth discussion when necessary to develop supports and appropriate programming. At the June 2011 Monitors' meeting with DADS and DOJ, there was discussion regarding determining the definition and criteria for facilitation, that is, what does it mean for the QDDP to facilitate the PST in a way that meets this provision item Some positive steps the facility had taken to address this item: • A QDDP Educator had been hired. • QDDPs completed facilitation training. • QDDPs received additional training related to risk assessments and action plan development. • QDDPs were trained on the assessment process. • The assessment tracking process was updated. The facility's POI indicated noncompliance with this requirement. The monitoring team agreed with that assessment. It will be important for the QDDP's to gain, use, and maintain effective facilitation skills.	

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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.	A sample of attendance sheets was reviewed with the following results in terms of appropriate team representation at annual PST meetings. The sample included PSPs for the following individuals: Individual #66, Individual #214, Individual #336, Individual #294, Individual #265, Individual #292, Individual #18, Individual #132, Individual #321, Individual #325, Individual #193, and Individual #248. • Eleven (92%) of 12 indicated that the individual attended the meeting; o The exception was Individual #66. • Six of the individuals in the sample had a guardian. Two (33%) of six participated at the annual PST. o Exceptions included Individual #214, Individual #66, Individual #265, and Individual #321. The monitoring team does not expect that all individuals or their LARs will want to attend their PST meetings. When individuals are not present for meetings, the QDDP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the team should look at what factors contributed to the refusal to attend and brainstorm ways to encourage participation. A review of 12 signature sheets for participation of relevant team members at the annual PST meeting indicated that two (17%) of the meetings were held with <u>all</u> relevant staff in attendance. There was no documentation included in any of the PSTs that would indicate input was given prior to the meeting by staff that were unable to attend the meeting. Some examples where team participation was not found to be adequate include: • A review of the attendance sheet for Individual #66 indicated that neither he nor his guardian attended his annual PST meeting. He was at risk for aspiration, constipation, gastrointestinal problems, osteoporosis, seizures, skin integrity, poor oral hygiene, and fractures. He had numerous complex health risks. He needed intensive supports for nutrition, communication, mobility, and positioning. His OT, SLP, dietician, direct support staff, and active treatment staff did not attend his annual PST. Professional staff should have been in attendance to contribute their expertise in developing appropriate supports to address his identified risks and ensure adequate programming was in place. Direct support staff that often know the individual the best and can contribute information regarding preferences, support needs, and any changes in functioning status. • Individual #336 was diagnosed with obesity, GERD, hyperlipidemia, and cardiomegaly. His dietician did not attend his annual PST meeting and did not complete his annual nutritional evaluation prior to the team meeting. Direct support staff did not attend the meeting.	Noncompliance

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		• Individual #18 had a complex support needs related to his risks in the areas of aspiration, choking, weight, osteoporosis, cardiac disease, constipation, skin integrity, falls, challenging behaviors, dental hygiene, seizures, and infections. Members of his team not in attendance at his annual PST meeting included his OT, SLP, Dietician, and day habilitation staff. The dietician did not attend the annual PST meeting observed for Individual #285. During the risk discussion, PST members present had several questions regarding his diet and weight loss. The team did not have the information needed to make an informed decision without consultation from the dietician. It was determined that a meeting would have to be held later to get the dietician's input. The dentist was not present and had not submitted a report prior to the meeting, so team members were unsure of any supports that may be needed in regards to dental hygiene. The facility found similar finding regarding the lack of attendance by key staff members in the self-audits of the PSP process conducted in June 2011, July 2011, and August 2011. The absence of key members was a significant barrier to integration in the development of PSPs. It would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. The facility had recently implemented new notification procedures and a data base to track attendance at PST meetings for relevant team members. • QDDPs were retrained in using Go to Meeting electronic meeting invitation notices to invite all team members to the meeting. • All PST members and department heads received training on roles and responsibilities in regards to PSP attendance. • A DSP attendance schedule for PSPs was implemented • An audit process of PSP attendance was implemented. • The QDDP Coordinator began notifying supervisory staff when PSP participants did not attend meetings. These processes were new, but should have a positive impact on meeting participation. In PSPs reviewed, team participation by PNM staff was rarely sufficient for individuals with identified support needs in communication, mobility, and dining.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient	Steps the facility had taken to improve the assessment process used for planning included: • The speech therapist trained QDDPs on what to expect from speech assessments and evaluations.	Noncompliance

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	quality to reliably identify the individual's strengths, preferences and needs.	• Admissions/Placement Coordinator provided training to QDDPs on the Living Options Assessment. • The Rights Officer provided training to QDDPs on completing the Rights Assessment. • The facility added an area on assessments for each discipline to express an opinion regarding the appropriateness of community placement. • The Q Coordinator, Lead QDDPs, and Active Treatment Supervisor received training on implementation of the new statewide Functional Skills Assessment tool. • QDDPs received additional training on the risk assessment process and developing action plans to address risks. • QDDPs began using a new electronic assessment tracking system. • PSTs began using the new Personal Focus Assessment (PFA) to develop priority outcomes for individuals. • The Clinical IDT was developing tools to assess the quality of assessments. The monitoring team found the quality and timeliness of some assessments continued to be an area of needed improvement. In order for adequate protections, supports, and services to be included in an individual's PSP, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed (see sections H and M regarding medical and nursing assessments, section I regarding risk assessment, section J regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, section R regarding communication assessments, and section T regarding most integrated setting practices). The PFA was an assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the PSPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual PSP. This list was individualized to some extent, and offered a good starting point for plan development. PFAs were completed prior to the annual PST meeting for all individuals in a sample of 15 reviewed for this requirement. The list of preferences developed from the PFA process was reviewed for 15 individuals. Teams were at varying stages in developing a list of priorities and preferences that could be used for planning. For example, • The PSP for Individual #132 included a somewhat generic list of the following preferences: socializing with staff, smoking, cokes, going on trips to town to go shopping or out to eat, and playing games with staff and peers. This list did not give enough information to be beneficial in planning a full range of supports and	

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		services. Although the PFA did not describe his preferences in-depth, it did include additional information regarding things that were important to him that might have been useful for planning. His PFA noted that he would like to be more independent, he did not like being told what to do or not being able to do things the wrong way; TV and music helped him calm down; he enjoyed being outside, quiet places, and walking; and he needed assistance with money management. • Individual #325's PSP, however, included a good example of a more individualized list of preferences that would be a basis for person centered planning. Her list included having staff talk to her and noted that she would respond by turning her head, listening to music, and moving her arms to the music; she liked the sun on her face, going out to eat and shopping, going to the Suzy Crawford Center for activities, van rides, feeding the ducks at the park, quiet areas without a lot of light, being warm, personal things in her room, and eating hamburgers and fries. Information gathered from the PFA was discussed in the PST meetings observed. Each QDDP reviewed the individual's list of preferences and members of the team engaged in limited discussion on how this might be supported. Attempts were made to integrate these preferences into outcomes developed by the team. Teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. The facility was transitioning from use of the Positive Assessment of Living Skills (PALS) to using the Functional Skills Assessment (FSA) to assess each individual's functional skills. As with the PALS, the FSA will not be beneficial to teams if it becomes a rote checklist to be completed annually. Staff completing the assessment will need to put thought into information gathered from the assessment and make recommendations that will assist the team in planning. FSAs had been completed for Individual #214, Individual #251, Individual #325, Individual #132, Individual #18 and Individual #265. The FSA for Individual #132 was the only assessment in this sample that included specific recommendations for training. Staff were completing the checklist, but not developing individualized recommendations from assessment results. Some examples where adequate assessments were not completed for the individual prior to the annual PST meeting, or updated in response to significant changes included: • Individual #18's annual PST meeting was held 7/26/11. His functional skill assessment was not updated prior to the meeting. He had a PALS assessment dated 7/22/10 and a FSA dated 9/19/11. Other annual assessments not updated and submitted at least 10 days prior to his annual meeting included: SLP evaluation (12/17/10), rehabilitation therapy evaluation (6/1/10),	

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		psychological assessment (7/15/10), physical examination (1/4/11), nutritional evaluation (8/1/11), and audiological evaluation (7/18/11). • The PSP for Individual #294 indicated that he had "significant medical issues," eight falls within the previous year, and a diet plan to address his weight. His nutritional evaluation (9/18/11), annual physical (2/24/10), and rehabilitation therapy assessment (9/10/10) were not updated and available for team review at least 10 days prior to his PST meeting. His rehabilitation therapy assessment recommended a GI consultation. There was no evidence that this consultation was obtained. • Work was a priority for Individual #193. A vocational assessment was not completed prior to her annual PSP meeting. As noted in the last monitoring report, vocational assessments did not adequately address job placement preferences, skills, and employment supports needed for community employment. For example, the vocational assessment for Individual #265, listed some of his work strengths and preferences, but did not describe employment supports that he may need, include recommendations for further work skill development, or address work exploration opportunities. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the PST meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	PSPs included a summary of assessments information and recommendations, but as noted in F1c, it was not evident that assessments were completed prior to the annual PST meeting, were adequate to address needs, or were revised as individual's needs changed. In order to gain substantial compliance with F1d, an adequate assessment process will have to be in place. QDDPs were still at varying stages in integrating information from assessments into a meaningful plan that identified supports in relation to the individual's preferences and needs. None of the plans in the sample offered clear guidance to direct support staff on all supports needed by the individual throughout the day. There were still some plans in the sample where QDDPs were "cutting and pasting" information from assessments into the narrative section of the plan without any additional discussion of how direct care staff should support the individual throughout the day. The use of clinical terms throughout some PSPs would make it difficult for direct support staff to understand how assessment recommendations should be implemented. An example of a plan that did a better job of integrating information into an easy to understand and follow plan was the	Noncompliance

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		PSP for Individual #336. Examples of PSPs where supports were either not addressed or difficult to understand included: • The narrative portion of the PSP for Individual #294 included a "cut and paste" summary of current assessments, but did not describe supports needed. For example, in regards to dental care, the plan stated "does have a medium periodontal risk with Type II periodontal disease. Noted halitosis upon physical assessment. This pre-sedation has worked well in the past." Narrative information should have included any support needed in regards to daily dental care and desensitization strategies needed for dental appointments. • The PSP for Individual #214 offered a clearer description of his diagnoses and risks, but again did not describe how staff should provide supports on a daily basis to address those risks. For example, his PSP noted that he had a diagnosis of GERD and took medication which was "highly effective." He was rated as medium risk for GI issues. There was no additional information included regarding daily supports that might reduce his risk of GERD symptoms (such as foods to avoid, positioning after meals, etc.). Similarly, his diagnosis of dementia was addressed by noting medications that he was taking, but included no strategies for direct support staff to follow in providing daily supports. As evidenced by the following examples, assessments included important information that should have been used as the basis for planning for individuals, however, this information was not always used to develop and implement protections, services, and supports for the individual in the PSP. • Individual #50's PSP noted that a top priority for him was his ability to communicate effectively to his staff and others around him. His speech-language evaluation described how he communicated and included recommendations for supporting communication. This information was not included in the PSP. His PFA also described his communication style and noted that he had a communication device that did not work well for him. There was no indication that the team discussed the need for an alternate communication device. His PFA indicated that he liked helping with chores, having money, and could do a variety of jobs. The team did not discuss employment exploration or opportunities. The PFA included a fairly thorough description of his preferences, likes, and dislikes. Most of the information was not included in his PSP. • Individual #116 had been the subject of 114 restraints in the past six months for crisis intervention. Her PSP offered staff very little guidance for addressing behaviors leading to restraints throughout her day. There was no reference to her behavior support plan or safety plan for crisis intervention. She took multiple psychotropic medications. Her PSP did not discuss risk indicators that direct support staff should monitor in regards to her medications.	

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		• The PSP for Individual #283 included conflicting information regarding his communication skills. One paragraph stated that he had "functional and thorough means of communicating his daily wants through speech." The next paragraph stated, "dependent on caregivers to predict his needs and interpret nonverbal vocalizations, gestures, and movements as meaningful communication." The facility was not yet in compliance with this item. QDDPs will need to ensure that all relevant assessments are completed prior to the annual PSP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	DADS Policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual PSP meeting at minimum. A sample of 15 PSPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement as required. This included the PSPs for Individual #120, Individual #116, Individual #6, Individual #193, Individual #188, Individual #39, Individual #38, Individual #194, Individual #19, Individual #385, Individual #283, Individual #325, Individual #214, Individual #330, and Individual #18. In 14 (93%), this discussion took place at the annual PST meeting. The exception was the PSP meeting for Individual #116. Her PSP indicated that the team had discussed community placement outside of the PSP meeting, as recommended by the psychologist. As evidenced by the summary below, this discussion, however, was not always adequate (also see section T of this report). • For Individual #18, the team did not indicate that there were barriers or obstacles to living in a less restrictive environment with appropriate supports. He did not appear to understand or be interested in community living option information presented to him. The MRA concluded that community placement was not recommended for him, but she would continue to offer him information. The team should discuss presenting information to him in a way that he will understand what his options include. Additional strategies to offer greater exposure to the community should be included in his PSP. • Individual #336 had been referred to the community according to his PSP dated 7/19/11. The team did not develop strategies that would help him to transition to the community at his annual PST meeting. • The PSP for Individual #194 noted that during a discussion of living options with the MRA, she indicated that she would like to move to a group home. The PSP	Noncompliance

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		was not clear on any possible barriers to community placement. The PSP described an increase in self-injurious and aggressive behaviors that appeared to be related to her current environment. She indicated that she was not interested in living in a less restrictive home at SGSSLC. The team needs to explore community living options that would provide appropriate behavior support in an environment that would meet her preferences. • The PSP for Individual #19 indicated that she was aware of community options and would like to move into a group home. The PSP noted that there were behavioral concerns that the team would like her "to improve on before considering community placement." The team had not discussed optimal placement in terms of injuries and incidents that had occurred in her current environment. Since 5/1/11, she had six injuries caused by aggression from peers. The team needs to consider whether or not her current environment is the safest place for her. Furthermore, she was not on the list of individuals who had requested community placement that was maintained by the APC (see sections T1a and T1h). • The PSP for Individual #385 indicated that he did not have full understanding of community living options. His guardian indicated that he would like to see him living in a smaller home. The team did not list any obstacles to placement besides his preference to live with his family. The PST concluded that the individual, his guardian, and the PST agreed that the most appropriate living environment was at SGSSLC further stating, "this will give him the opportunity to prepare for a community referral by demonstrating the ability to make good choices with less assistance from others." There was no clear link between the community living discussion and this final determination. Discussion at PST meetings observed regarding community living options was not adequate: • During the annual PST meeting for Individual #285, he stated that he would like to live in an apartment in the community with supports. Several members of his family joined the meeting by teleconference. They also agreed that supported living would be optimal placement for him. The family agreed to provide many of the supports that he would require in the community. The team did not name any obstacles to placement in the community. Much of the discussion was prefaced with the statement "when the time comes" or "when he is ready." There was no discussion regarding how that would be determined. The QDDP asked the individual what he needed to work on to move out. He stated, "be good." According to the psychologist, he was doing well, with no major problems identified. The team agreed that he would need a job when placed in the community. He had a job on campus, but lost his job because he was assigned to	

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		attend classes during work hours. Vocational staff reported that he would not be able to work at the job that he was interested in because of his class schedule. Since work was a priority for him in the community, the team should have held an integrated discussion regarding job skills and supports. The team did not even ask him what type of job he was interested in, so there was no basis for determining what employment training he needed to prepare for community employment. There were some common themes among the discussion and determination of optimal living placement in the PSPs reviewed: • Teams were not able to determine the preferences of individuals due to lack of exposure to other living options or inability to communicate choices and preferences. • Community integration and employment was not adequately addressed in any of the PSPs reviewed or at any of the PST meetings observed. • Measurable action plans with reasonable timelines for completion were not developed when PSTs agreed that placement in a least restrictive environment would be an appropriate consideration • Behavior incidents triggered by environmental factors were often considered barriers to placement in alternate living environments rather than a consideration for determining that another placement may be more appropriate for an individual. PSTs need to give consideration to the following: • The primary focus of all PSTs should be to provide training and supports that would allow each individual to live in the most integrated setting possible. • Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility when these are identified as barriers to living in a less restrictive setting. • Team members need to be provided with updated training on services and supports that are now available in the community. • As evidenced by the injuries and incidents that occurred at the facility, SGSSLC may not be the safest or optimal living environment for all individuals. The team needs to review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual. Plans included limited opportunities for community based training. None of the plans in the sample included opportunities to develop relationships and gain membership in the	

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		community. Although the facility reported that some training was occurring in the community, it was not evident in PSP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. According to the Vocational Director, situational assessments were being performed at the facility with various jobs at the facility. The facility will need to find a way to capture this information and ensure that it is shared with PSTs and used during the planning process. The facility was also beginning to explore volunteer opportunities in the community. These opportunities are a good way to develop relationships and explore work. The facility will need to develop a way to document training occurring during volunteer activities. There was very little focus on community integration at the facility and teams did not have the knowledge needed to develop plans to be implemented in the least restrictive setting. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that	The facility POI indicated that training was occurring in regards to developing action plans to address preferences. Additionally, all discipline heads were trained on implementing plans that focused on community integration. The PSPs reviewed continued to include a list of the individual's preferences and interests. For individuals in the sample, this list was used as the basis for outcome development. Limited exposure to new activities meant that this list was often limited. In order to meet compliance requirements with F2a1, PSTs will need to identify each	Noncompliance

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	are needed, and encourages community participation;	individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences. PSPs reviewed were reflective of the lack of options and programming available at SGSSLC. While some plans included opportunities to take trips to the community, and minimal training opportunities in the community occurred, none presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Meaningful supports and services were not put into place to encourage individuals to try new things in the community.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	QDDPs received training on Action Plans and Review Process in October 2011. The QDDP Coordinator and QDDP Educator were reviewing plans for compliance with this requirement. Plans in the sample reviewed were written prior to this new training. Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. PSPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs. Outcomes were not written to address all preferences and were not written in a way that progress or lack of progress could be consistently measured. For example: • Individual #132 had an outcome to "break through barriers to community placement." Action steps included a BSP, continue to educate on living options outside of the facility, and LOS. These brief descriptions offered no direction to staff implementing the plan or specified when progress would be sufficient for referral for placement in the community. There were no corresponding skill acquisition plans, though the action steps were to be recorded on an SAP. Other action steps with no direction and no corresponding skill acquisition plan included a money management objective and a self medication objective. He was at high risk for falls and his risk action plan had an objective that stated "will exhibit 0 fractures in a 12 month period." There were no corresponding PNM objectives and no direction for support staff to follow to provide appropriate supports to address his risk for falls. • Individual #252 had an outcome stated "Going to a group home in the community closer to her family." The action steps included "will continue to display 0 challenging behaviors even though BSP was discontinued." The PSP did not define challenging behaviors. Responsibility was assigned to the	Noncompliance

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		psychologist. Direct support staff were not directed to provide any supports in regards to behavior. Similarly, she had an action step to "have successful home visits with no behaviors." There were not specific behaviors listed. It was not clear what action the individual would have to take to successfully complete this objective and move closer to community placement. • Individual #193's PSP included six outcomes with numerous corresponding action steps. Direct care staff was not assigned responsibility for any of the action steps, though several involved monitoring for health care and behavioral risks throughout her day. Action plans often referred to additional plans (i.e., HMP, PNM plans) that were not integrated or even attached to the PSP. Specific supports and strategies to achieve outcomes were not included in the PSP. Skill acquisition plans were developed for three specific action steps. Individualized recommendations from assessments were not incorporated into the teaching strategies Teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. See section F1e and T1b for additional comments related to this requirement.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted in F1d, recommendations for assessments were not integrated into supports for individuals. PNM, healthcare management plans, and dining plans were not submitted as part of any of the PSPs in the document request. These plans should be attached to the PSP and considered an integral part of the plan. When developing the PSP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, PSPs generally described the timeframes for completion and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail section S of this report. Professional or supervisory staff were often designated as the responsible person in action plans. Direct support staff's role was not specified when, in fact, they typically played a key role in monitoring healthcare needs and providing daily support. The PSP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in PSPs. A new skill acquisition plan format was recently implemented. A QDDP Educator had	Noncompliance

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		been hired to monitor plan development and implementation. See section S for further comments regarding this new process. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The role of direct support staff in implementing plans should be clearly documented in the PSP.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The facility had made little progress towards compliance with this item. As noted throughout the report, plans did not always adequately address supports needed by the individual to achieve the outcomes. Minimal functional learning opportunities were included in the PSPs in the sample. As noted throughout other sections of this report, there is need for improvement in the development of plans to address risk for individuals, psychiatric treatment, healthcare issues, PNM needs, and behavioral support needs. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Few training opportunities were offered in a natural setting, such as the home or community. There were certain constraints due to the fact that individuals were living at the facility rather than in the community that limited functional training opportunities. For instance, individuals did not participate in meal preparation and service. They did not bank in the community, or go to the pharmacy to get their medication. They did not have routine access to stores, libraries, and other facilities. They were not able to choose, join, or regularly participate in group and social activities such as church, art, and gym classes. Interventions, strategies and supports did not adequately address individual's needs and many were not practical and functional at the facility and/or in community settings.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the	PSPs identified the person responsible for implementing service and training objectives and the frequency of implementation. PSPs also included a column to note where information should be recorded. Data collection sheets were generated for some service objectives, but not all. A person was assigned to collect data, but it was not clear what happened with the information gathered from this process in terms of making changes when an outcome was completed or when there was no progress made. Training program/data collection sheets were generated for training objectives. This form included what data would be collected, the frequency of data collection, who would collect data and who would monitor data. It was not evident that team members were using data collected to drive planning in	Noncompliance

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	data review.	regards to necessary supports. This was particularly true in regards to risk discussions. Data that should have been reviewed by the team included test/laboratory results, skill acquisition goal data, injury and incident data, data related to nursing care plans (weight, number of seizures, hospitalizations, etc.), behavioral data, and response to medications. See section I for additional comments regarding adequately identifying risks. See section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision item will also require compliance with several sections throughout this report including confirmation that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services. Please refer to these sections of the report regarding the coordination of services as well as section G regarding the coordination and integration of clinical services. As noted in F1b and F1c, representation from all relevant disciplines was not evident during planning meetings and adequate assessments were not completed prior to the annual meetings. The facility did not have a process to ensure coordination of all components of the PSP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current PSPs were not available in 18 of 23 (22%) of the records, indicating that support staff did not have information necessary to fully implement PSPs. This was noted to be a problem during the last monitoring visit. Although this was a slight improvement from the last monitoring visit, there were still a significant number of plans not available to staff providing supports. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding of job responsibility. As noted in F1d, plans still contained clinical jargon where assessment information was just cut and pasted into the plan with no real description of what supports were needed. Many health and therapy related outcomes did not assign responsibility to direct support staff who would need to carry out the plan. As noted in F2a4, plans did not offer a clear guide on who would be responsible for plan	Noncompliance

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		implementation. As a direct support professional, it would be difficult to read the PSPs as written and determine what supports should be provided for an individual during the course of a 24-hour day. Lack of integration of plans contributed to this confusion. Many separate plans existed that were not integrated into the one comprehensive plan. As the state continues to provide technical assistance in plan development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation. The facility remained out of compliance.	
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 POI indicated that Section F audits completed June 2011-August 2011 found significant problems in consistent review and revision of plans as needed. Self-assessment overall scores for this provision item were at 33% in June 2011 and July 2011 and 67% for August 2011. Additional training was provided to QDDPs in October 2011 regarding the monitoring and review of action plans. It was too early to determine if this training was effective. At the annual PSP meeting for Individual #285, there was a lengthy discussion regarding his risk for weight gain. Team members were not sure how much weight he had lost or how effective his current diet had been at achieving his outcome for weight loss. This should have been tracked monthly and reviewed by the QDDP if it was not effective prior to the annual team meeting. Similarly, all team members were not aware that he had lost his job at the facility due to scheduling conflicts with his classes. The team should have been notified when this occurred and supports should have been put into place immediately for him to continue working. He was frequently not attending the workshop due to a conflict with another individual. The team had not met to try to resolve the conflict prior to addressing it at his annual team meeting. A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. As noted throughout this report, it was not evident that teams were aggressively addressing regression, lack of progress, and risk factors. For example, the PST met when Individual #243 was the victim of aggression by another peer four times over a seven day period. The team concluded that Individual #243 had an extensive history of starting verbal altercations with peers that instigated them to the point of retaliation. Recommendations were to continue to follow her BSP for verbal aggression and for staff to continue to redirect her when she was in a verbal altercation with peers. This plan had not proven to be effective according to the number of incidents occurring, but was not revised. Her PST had also met to discuss a nine pound weight gain in a month period. The team concluded that he weight gain may be related to a change in medication. The team recommended notification of the psychiatrist and waiting for any recommendations. There was no	Noncompliance

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		evidence of follow up by the PST. Her PST met seven times between 3/30/11 and 6/13/11 to follow up on chemical restraint incidents. The team continued to recommend following her BSP and SPCI to address challenging behaviors. She did meet with the psychiatrist during that time and her medication was changed. The team did not discuss environmental factors that might have contributed to behavior resulting in restraints. QDDPs completed quarterly reviews. The quarterly review form included a section to note progress or regression on all service and training objectives monthly and a place for QDDPs to comment quarterly on the progress or lack of progress. It was not evident that this process was thorough enough to adequately assess the progress and efficacy of the related interventions. Examples of findings: • The quarterly review for Individual #18 dated 10/27/11 offered little information on his progress or response to the implementation of outcomes. He had an outcome to tour community living options. The QDDP noted "site tour done." There was no additional information on where he went or how he responded. For his outcomes to attend community events, participate in activities at the Suzie Crawford Center, learn cart safety, follow recommendations of the PNMT, follow his current diet, make choices, and be involved in leisure activities, the QDDP only documented "no problems noted" for each quarter. There was no information on the number of times implemented, a description of activities, or his response to various activities. Other outcomes had a number in the column under each quarter. It was not clear if this was the number of times implemented or the number of times successfully completed. Again, no comments were made in regards to his response to implementation, progress, or regression. • The quarterly review for Individual #336 dated 10/26/11, however, was a much more thorough review of supports and services. The QDDP noted progress, regression, or lack of participation for each outcome and service. Additional notes were made in regards to implementation. For example, for SOTP attendance, the QDDP noted progress in each month of the quarter and commented that his "participation and attendance had been excellent and has demonstrated that he chooses to use his coping skills outside of the classroom setting." In regards to a recommendation for a PSA test, the QDDP noted that the test was completed and there were no concerns at this time. A summary of each discipline's review was included in the quarterly review. The team reviewed his injuries and incidents, risk ratings, appointments, and restrictions. Data were included where relevant. Monthly and quarterly reviews should address the lack of implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the quarter	

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		should be documented. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QDDPs need to keep in mind that PSPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	In order to meet the Settlement Agreement requirements with regard to competency based training, QDDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive PSP document. • A review of training transcripts for 24 employees indicated that 24 (100%) had completed the new training on PSP process entitled Supporting Visions. • All QDDPs had attended Q Construction: Facilitating for Success training. As evidenced by findings throughout this report, training on the implementation of plans was not ensuring that plans were being implemented as written. The QDDP Coordinator was aware of deficits in the implementation of the PSP and was providing additional training to QDDPs in monitoring for this requirement. The facility's POI indicated noncompliance with this requirement. The monitoring team agreed with that assessment.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP	Of PSPs in the sample reviewed, all (100%) had been developed within the past 365 days. PSPs were reviewed for two recent admissions. Abbreviated admission PSPs were developed for both Individual #157 and Individual #355 within 30 days of admission to the facility. As noted in F2c, a sample of 23 plans was reviewed in the homes to ensure that staff	Noncompliance

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	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.	supporting individuals had access to current plans. It was found that 22% of the plans in the sample were not current. This is concerning for a number of reasons. The PSP should be the plan that ensures all support staff have information regarding services, risks, and supports for individuals in the home. Without it, staff did not have the tools that they needed to safely and consistently support individuals. According to the QDDP Coordinator, as of 8/15/11, QDDPs were required to complete PSPs the day after the meeting was held. As noted in F2d and other areas of this report, plans were not always revised when supports were no longer effective or applicable.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility had a tool to monitor PSPs to ensure the development of a comprehensive PSP that addressed all services and supports. The facility had generated a report from data collected from observations and document reviews using the statewide audit tool for Section F, SGSSLC Staff Interview/Observation tool, and the PSP monitoring tool that was revised locally on 9/7/11. Three audits per month were being conducted by the Lead QDDPs, the QDDP Coordinator, and Residential Coordinator. Compliance scores from the self-audit were between 19% and 67%. Overall compliance for Section F requirements was 48%. Quality enhancement activities with regards to PSPs were still in the initial stages of development and implementation (also see section E above). The facility was just beginning to analyze findings and develop corrective action plans. An effective quality assurance system for monitoring PSPs was not fully in place at the facility.	Noncompliance

Recommendations:

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

2. It will be important for the QDDP's to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify (F1a).

3. When individuals are not present for meetings, the QDDP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the team should look at what factors contribute to the refusal to attend and brainstorm ways to encourage participation (F1b).

4. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the PST meeting to facilitate adequate planning. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community (F1c).

5. A description of each individual's day along with needed supports identified by assessment should be included in PSPs. All supports and services should be integrated into one comprehensive plan (F1d).

6. Provide additional training to PST members on developing and implementing plans that focus on community integration. (F1e, F2a).

7. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility (F1e).

8. Therapists should establish SAPs for interventions with measureable goals and clear consistent reporting on progress within the PSP system.

9. QDDPs need to be provided with additional training on facilitating the living option discussion with family members (F1e).

10. PSTs should review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual (F1e).

11. PSTs will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

12. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The PSTs should develop action steps that will facilitate community participation while learning skills needed in the community (F2a1).

13. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs (F2a2).

14. PSTs should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual (F2a3).

15. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The PSP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in PSPs (F2a4, F2c).

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

17. Outcomes should identify the data to be collected and/or documentation to be maintained, the frequency of data collection, the person(s) responsible for the data collection, and the person(s) responsible for the data review (F2a6).

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

19. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues. (F2d)

20. Develop a process to revise PSPs when there is lack of progress towards PSP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings. Review and revise plans when there has been regression or a change in status that would necessitate a change in supports. Ensure that staff are retrained on providing supports when plans are revised (F2d, F2e, F2f).

21. Develop an effective quality assurance system for monitoring PSPs (F2g).

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o Presentation Book for Section G o SGSSLC POI, 11/22/11 o SGSSLC Policy/Procedure: Consultation Process, 12/8/09, rev. 8/25/11 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o SGSSLC facility-specific policy, Minimum Common Elements of Clinical Care, 10/6/11, revised 11/3/11 o Clinical IDT meeting minutes, 8/18/11, 9/29/11, 10/6, 10/13/11, 10/20/11, 10/27/11, and 12/8/11 o Quality Improvement Council Notes, 6/27/11, 7/5/11, 7/18/11, 7/25/11, 8/22/11, 8/29/11, 9/19/11, 9/26/11, 10/17/11, 10/19/11, 10/24/11 o QI Council Meeting: Quality Assurance Report, October 2011 o Review of records listed in other sections of this report Interviews and Meetings Held: o Rebecca McKown, Medical Director, o Angela Garner, CNE o Lisa Owen, QA Nurse o Charles Njemanze, Assistant Director of Programs o Unit Directors: Cedric Woodruff, Vicki Hinojos, Tricia Trout Observations Conducted: o Clinical IDT meeting, 12/8/11 o PSP meeting for Individual #376 o Daily clinical meeting o Medication Review Committee meeting o Medication Variance Committee meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment, the POI. It was updated on 11/22/11. The POI provided a series of detailed updates on the various meeting, initiatives, policies and procedures that were developed to assist in achieving substantial compliance. It also provided information related to compliance data associated with items in G2. The facility found that it was noncomplaint with both provision items. The findings of this review led the monitoring team to agree with the facility's self-ratings.

	Summary of Monitor's Assessment: The SGSSLC staff invested significant time in working towards achieving compliance with this provision. Continued progress was noted in this area by the various initiatives that were implemented. The medical director remained in the lead role and was aware of the importance of adequately integrating clinical services. Those efforts were quite visible to the monitoring team throughout the week of the review. There were several positive findings related to collaboration and integration. Unfortunately, there was also evidence that in some areas there was a near total disconnect among the clinical services and this contributed to a lack of positive outcomes for individuals. This will likely improve as the facility director assumes the lead role and fosters even a greater sense of collaboration and accountability among the various disciplines. SGSSLC is in need of further direction by guidance from state issued policy. Additionally, a valid and reliable monitoring tool is needed. This will require that the facility determine what it needs to measure and identify the metrics that will be utilized for measurement.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	SGSSLC continued its efforts towards achieving compliance with the Settlement Agreement. Recognizing the importance of integration of clinical services, state office recently issued a directive that required the facility director to serve as the lead person for this provision. The medical director continued in the lead role, but reported that the director received copies of the minutes from the weekly meetings. Given the facility wide requirements for this provision, the monitoring team believes that transitioning the facility director into this lead role is a key step in helping to coordinate services and achieve compliance with this provision. Throughout the various meetings, it was clear that the discipline heads were aware of the importance of integration of clinical services. Many prefaced statements with comments related to how actions helped to foster integration. It was good to see there was substantial buy-in on the part of clinical leadership with regards to the necessity of integrating clinical services. The monitoring teams had presented to DADS and DOJ a listing of activities in which the SSLCs might engage that would indicate the occurrence of the provision of integrated clinical services. This list (i.e., criteria) was being reviewed by DADS and it is expected that over the next several months, this list will be finalized and can be used by each facility. A draft DADS statewide policy had also been available for a number of months. It addressed both integrated clinical services (section G) and minimum common elements	Noncompliance

#	Provision	Assessment of Status	Compliance
		of clinical services (section H). Throughout the week of the review, the monitoring team observed several activities and meetings that offered either direct evidence of integration or demonstrated how the facility continued it efforts to improve integration: • The facility continued to hold a weekly meeting of the heads of the clinical departments that was led by the Assistant Director of Programs. This was called the Clinical/IDT meeting. The monitoring team reviewed a set of minutes from seven meetings held from August 2011 through the meeting observed by the monitoring team on 12/8/11. It appeared that relevant topics were discussed. Most were related to areas of the Settlement Agreement that required cross-discipline integration: identifying and addressing risk, desensitization programming, assessing the quality of clinical assessments, provision G, and provision H. Progress appeared to be occurring. o The group had recently designated one of their meetings per month to focus on a particular individual and do an in depth review and discussion of his or her risk issues (identifying risk, determining level of risk, determination of action plan and follow-up). This sounded like a good use of the group's time once per month. o The minutes from that meeting (10/20/11) indicated good discussion. The other weekly meetings, however, did not focus on one or two specific disciplines per meeting as recommended in the previous monitoring report and as the monitoring team expected to find, based on discussions with the ADOP and SAC. The intent of that recommendation was to focus all attention on a single discipline (e.g., psychiatry, psychology, OTPT, speech and language, dietary) for a period of time (e.g., 30-45 minutes) during the meeting and solely discuss ways in which that discipline integrated with other disciplines and vice-versa. Including this type of discussion is not required for substantial compliance, but may help the facility to achieve substantial compliance. The monitoring team is available to further discussion regarding this recommendation. • The OTs and PTs had conducted position and alignment assessments in conjunction with dental to ensure proper support in the dental chair for examinations and to minimize risk of aspiration, but there was no evidence that there was continued periodic monitoring of this in the clinic. • There were two daily meetings held to help ensure that individuals received the clinical services they needed. All unit nurse case managers attended the morning meeting facilitated by the nurse operations officer. It provided the nurses with a brief report of medical concerns, training needs, and changes that	

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		required follow-up. The afternoon meeting occurred at 4:30 pm each day and was facilitated by the medical director. This meeting included representation from all medical/clinical departments and provided opportunity for integration between all services and discussion of the last 24 hours of medical/nursing care. It provided the opportunity to discuss facility wide events or problems with particular individuals. • There was a weekly medical-nurse meeting. • The primary providers, psychiatrists and pharmacy staff held weekly meeting on Thursdays to review medication issues including polypharmacy and restraint use. • There was good participation by medical nursing and psychiatry at the annual PSP of Individual #376. • Integration between psychiatry and psychology was in the early stages and observations in psychiatry clinic reveled good collaboration between the two disciplines during the clinic setting. • One significant collaborative project was the formation of a multidisciplinary Pneumonia Performance Improvement Team. This brought professionals together from several disciplines to address the important issue of aspiration and pneumonia. Notwithstanding a series of enormous efforts, the monitoring team noted several areas that were worthy of attention and improvement: • The medical director reported that the medical staff had good participation in the annual PSP meetings. The medical department did not track medical provider attendance at PST meetings and annual PSPs. There continued to be inconsistent evidence that individuals' physicians participated in their PST meetings, which was especially relevant when individuals' risk assessments and plans were reviewed and revised. • There was no neuropsychiatry clinic. The medical director reported that the consultation form was routed to all providers for input prior to clinic and a summation was generated. Upon return from consultation, the recommendations were forwarded to the primary providers and psychiatrists. • The PNMT did not generally receive referrals from the PSTs for individuals who would benefit from assessment and supports from this specialized team. The PNMT did, however, track the status of individuals and self-initiated assessment of individuals with changes in status such as hospitalizations, pneumonia, and other PNM-related concerns. Tracking trigger thresholds for specific high risk individuals may also be useful and result in a quicker response time to address issues in a more proactive manner rather than waiting until individuals were in crisis before more aggressive assessment and action plans were developed and	

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		implemented. • There was a notable lack of collaboration between dental clinic, medical, and psychology with regards to desensitization. Efforts related to desensitization appeared suspended for many months and were re-implemented in late October 2011. It appeared that psychology was considered the lead discipline for this process. While the actual plans may be generated by psychology, the referral, implementation, and follow-up actions truly require integrated efforts from all of the clinical disciplines. • The suction toothbrushing program was also an area that faltered due to a lack of collaboration between clinical services. Nursing actually provided the treatment to individuals and, therefore, was considered the lead for this program. None of the discipline heads involved (medical, nursing, and dental) could provide an accurate update on the status of the program or were even aware if any of the 31 recommended individuals were receiving the treatment. This was unfortunate given the importance of oral hygiene in general, but specifically with regards to efforts to minimize complications of aspiration.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility had implemented numerous processes to improve review of consultations and recommendations. The medical director was quite enthusiastic about these changes including the use of a new "stamp" and believed that this would address many concerns previously cited. Observations, interviews, document and record audits noted the following progress with regards to this provision item: • A stamp was developed to assist in routing of consultations, labs, and other reports. The back of documents were stamped with information such date revived, PCP signature, rounds, psychiatry signature, IPN updated, and physician orders updated. • The consultation policy required that the primary provider sign and date on the day reviewed. The RN case manager received the consults to ensure the primary provider could address on rounds within five working days. The primary provider was required to document all consultations in the IPN. An explanation was required when recommendations were not implemented. The communication with neurology policy added the requirement that the primary provider write an order for the RN case manager to communicate changes in status/plans with the PST. • The Hospital Liaison nurse was directly involved in the daily process of reviewing non-facility clinician's recommendations. Although there was an approximate four-month lapse in consistent delivery of these services due to the resignation of the former Hospital Liaison, the newly hired Hospital Liaison had	Noncompliance

#	Provision	Assessment of Status	Compliance
		immersed herself in the oversight of delivery of health supports and services to individuals by non-facility clinicians. She ensured that all individuals who were hospitalized were visited, and that all pertinent information about their hospitalization was collected and reported to their caregivers at SGSSLC. She communicated her assessment of individuals' hospital care/treatment and their response to treatment via daily written reports, which were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. The facility will need to put forth additional efforts related to this provision, as the implementation of processes does not always result in the desired outcomes. The following findings will need to be addressed: • Although multiple processes were implemented, reviews of records indicated that providers were not consistently documenting the consults in the IPN. There were several instances where record reviews indicated the reviews of consults were not timely. Although the monitoring team recognized that the tracking/stamping process was implemented shortly prior to the review, the requirement for physician documentation was in place for many months. • There was no evidence across 20 of the 20 sample records reviewed that their nurses consistently reviewed non-facility clinician's reports and recommendations and ensure that the clinician's recommendations were addressed/implemented in a timely manner. This resulted in the policy change requiring the provider to write an order for the RN case manager to communicate with the PST. • A comprehensive consultation database was lacking. Nursing maintained a log that contained the date consults were requested and the date it was completed. It did not contain information on receipt of the actual consultation form. The medical director stated that the medical department did not have access to this database.	

Recommendations:

1. DADS should develop and implement policy (G1 G2).
    a. The policy should include items agreed upon by the monitoring teams, DADS, and DOJ.
    b. The policy should consider including items (and possibly definitions) in the SGSSLC facility-specific policy.

2. Develop facility-specific policies through the required approval process (G1).

3. Develop a system to assess whether or not integration of clinical services is occurring (i.e., self-monitoring). This will require creating

measurable actions and outcomes (G1).

4. Address the items above in G1 identified as needing attention and improvement (G1).

5. Consider the inclusion of a statement regarding the integration of clinical services in each individual's PSP document (G1).

6. Explore options for achieving integration of psychiatry and neurology (G1).

7. Complete medical audits to determine compliance with requirements for documentation of consultations in the IPN (G2).

8. The consultation database should be expanded to include additional information. This could be a simple spreadsheet with one line for each consultation that identified the individual, date consult ordered, date appointment scheduled, date consult completed, date of formal consult. This information should be made available to the medical department as well as the records department (G2).

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o Presentation Book for Section H o SGSSLC POI, 11/22/11 o SGSSLC Policy/Procedure: Minimum Common Elements of Clinical Care, 10/6/11 o SGSSLC Policy/Procedure: Clinical Indicators for Direct Care Staff, 7/15/11 o SGSSLC Policy/Procedure: Consultation Process, 12/8/09, rev. 8/25/11 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o Clinical IDT meeting minutes, 8/18/11, 9/29/11, 10/6, 10/13/11, 10/20/11, 10/27/11, and 12/8/11 o Quality Improvement Council Notes, 6/27/11, 7/5/11, 7/18/11, 7/25/11, 8/22/11, 8/29/11, 9/19/11, 9/26/11, 10/17/11, 10/19/11, 10/24/11 o QA/QI Council Meeting: Quality Assurance Report, October 2011 o Review of records listed in other sections of this report Interviews and Meetings Held: o Rebecca McKown, Medical Director, o Angela Garner, RN, CNE o Lisa Owen, RN QA Nurse o Misty Menendez, SAC o Charles Njemanze, Assistant Director of Programs Observations Conducted: o Clinical IDT meeting, 12/8/11 o PSP meeting for Individual #376 o Daily clinical meetings
	Facility Self-Assessment: The facility last updated the POI on 11/22/11. It included information on the various initiatives underway at the facility. The updates, focused primarily on the development of the common elements policy, including implementation and training. The POI also documented data related to audits conducted to determine compliance with section G2, H, L and requirements for nursing documentation. The facility rated itself noncompliant with all provision items. The monitoring team is in agreement with these ratings. The action plan included a number of general steps related to development of the common elements policy. It also specifically outlined one step for every department director to develop monitoring systems. Some,

	but not all, of the tools were included in the presentation book. Given that state office has not issued a finalized policy related to this provision, it is not surprising that a significant amount of work remains to be completed.
	Summary of Monitor's Assessment: The chief nurse executive, who served as the lead for Provision H, participated by phone in discussions related to this provision. The other participants included the medical director, QA Nurse, and the SAC. The facility had written a policy for section H, called Minimum Common Elements of Clinical Care, and this provided a staring point for moving towards substantial compliance. During discussions, it was acknowledged that this was a very important provision and much work had gone into developing the policy. Provision H reflects a means of ensuring that all of the elements of clinical care are appropriately coordinated and monitored. There were many activities occurring in the facility that were connected to provision H, but were not clearly identified as such. Many of the activities in this provision are related to determination of quality and will require input on the part of the QA department. Overall, the monitoring team found that routine assessments were being completed, but in many areas these assessments were not being completed in a timely manner. Additionally, the content of the assessments in many areas will need improvement. The monitoring team also noted that there were some examples of clear deficits in the response of clinicians to a change in status. The monitoring team believes that additional direction from state office and the involvement of the facility director will be critical in helping to achieve substantial compliance.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The facility had written a facility-specific policy for section H, called Minimum Common Elements of Clinical Care, dated 10/6/11, revised 11/3/11. Many of the clinical department heads talked about participating in its development. The policy represented a good effort by the facility to try to provide guidance on how to meet the many requirements of this provision. It is likely that more revisions will be required as the facility attempts to implement this policy. The facility should ensure that this meets the requirements of the Settlement Agreement and that the policy goes through the DADS process for approval of facility-specific policies (see section V2 below). The minimum common elements of care policy, developed through the Clinical IDT, required that routine assessments be completed to monitor health status. According to the SAC, the initial focus was on medical, nursing, and psychology assessments. The policy, however, was inclusive of all discipline specific assessments. The Clinical IDT had	Noncompliance

#	Provision	Assessment of Status	Compliance
		taken measures to ensure that all disciplines developed assessments based on the same sets of information, included certain elements of the Settlement Agreement, and were monitored by discipline heads to determine program effectiveness. The Clinical IDT continued to work on assessing the quality of discipline assessments and ensuring that assessments achieved the appropriate outcomes across the Settlement Agreement. Throughout the conduct of the review, the monitoring team had the opportunity to evaluate routine assessments as well as assessments that were completed in response to a change in health status and noted the following: • There was improved documentation to reflect that the psychiatrists had been evaluating individuals, however, due to problems with the resignation of one of the prescribing practitioners, there was a noted overall deficiency per review of records. • There was improvement in completion of the Annual Medial Summaries, but there were issues identified with regards to the accuracy of information. Records reviewed indicated that Quarterly Medical Summaries were not consistently completed. • Current annual and/or quarterly nursing assessments were not present in 25% of the 20 records reviewed. • Quarterly and annual nursing assessments were not complete and/or accurate for all 20 records reviewed. In addition, despite numerous changes in individuals' health status and needs during the quarterly review periods, assessments were not reviewed/revised to ensure timely evaluation of and response to individuals' needs. • Functional assessments and Psychological assessments were not consistently completed for every individual at SGSSLC. • OT/PT assessments were not appropriately current for a number of individuals who required PNM supports. A new assessment format had been implemented and was an improvement in format and content. While there was some evidence of limited discipline-specific assessments based on change in status, these were insufficiently comprehensive (Individual #295). There were also examples of limited follow through to resolution of problems identified (Individual #288).	
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	The medical director reported medical and psychiatry had recently begun meeting to ensure that all psychiatric diagnoses were accurate and up to date. This process was in the initial stages and much work remained to be done. The monitoring team noted the following with regards to this provision item: • The majority of the medical documentation utilized appropriate ICD-9 nomenclature.	Noncompliance

#	Provision	Assessment of Status	Compliance
	Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	• The diagnostic formulation and psychiatric target symptoms selected for treatment recommendations were not well addressed. Aberrant behaviors such as aggression to self and others were the focus of the treatment recommendations. Clinicians should determine psychiatric target symptoms that established the reasons for the assigned diagnosis and then select psychopharmacology accordingly. • The majority of nursing assessments failed to result in a complete or accurate list of nursing diagnoses, in accordance with NANDA.	
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 CNE, as lead for this provision item, reported no evidence was available related to this item. Meeting compliance with this provision item required that the facility provided timely and appropriate treatments and interventions based on assessments and diagnoses and had evidence that this was occurring. In order to effectively measure if this occurred, the facility needed to conduct periodic assessments of these clinical activities using an audit tool that outlined the clinical outcomes. The monitoring team looked for evidence of this through activities such as observations, interviews and record audits and noted the following: • The facility completed a number of audits, such as the medical provider audits to determine compliance with this provision item. The actual breakdown for the provision item number was not provided. • Record reviews indicated that there were several instances in which the medical providers failed to document appropriate assessments for individuals with acute medical problems. Moreover, there were several examples of failure to provide adequate follow-up evaluations. • SGSSLC continued to have problems ensuring that that individuals' acute and/or chronic health needs were addressed by complete, individualized health plans that referenced adequate and appropriate treatments and interventions based upon the individuals' assessments and diagnoses. Their reliance upon stock care plans resulted in HMPs that referenced the same health goals and interventions regardless of the severity of the problems, the individuals' co-morbid conditions, the individuals' ability to understand and participate in the interventions, etc. • The diagnostic formulation and psychiatric target symptoms selected for treatment recommendations were not well addressed. Aberrant behaviors, such as aggression to self and others were the focus of the treatment recommendations. Clinicians should determine psychiatric target symptoms that established the reasons for the assigned diagnosis and then select psychopharmacology accordingly. • Twenty-five percent of the intellectual assessments of the psychological	Noncompliance

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		assessments were over 10 years old.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The local policy, consistent with the state draft policy, included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. This looked like a good start to assist the facility in meeting this, as well as the other, items of provision H. It would also appear that in selecting these data elements that the facility was establishing the framework for a medical quality program. The monitoring team noted the following through a series of document and record reviews: • Psychiatric documentation in records did not define what was being monitored. It was difficult to evaluate, if an agent was effective, especially if someone was administered polypharmacy, due to lack of a detailed rationale for each medication chosen. Polypharmacy was reportedly reviewed routinely in the Medication Review Committee, but the monitoring team was not provided minutes regarding this information. • Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised, and they did not reflect the most current conditions and intervention strategies. This problem was especially important because it occurred even when nurses' documented that they reviewed the plans. • With regards to habilitation services, there were generally no measurable goals established for interventions provided. Documentation was more anecdotal in nature making tracking progress and comparing/contrasting data to describe progress over time difficult As medical guidelines and various protocols roll out, the next step would be for the facility to select valid and reliable clinical indicators applicable to the various conditions being addressed. With regards to provision H, the facility will need to remain mindful that all clinical areas need to be addressed.	Noncompliance
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.	Over the past year, the way in which the facilities determined and managed risk was overhauled. The health status team system was discontinued and managing risk was incorporated into the PSP process. At the time of the onsite review, the health status of each individual was monitored through a series of assessments that included annual medical assessments and comprehensive nursing assessments. Quarterly pharmacy assessments were also	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed. Additional oversights, such as the adverse drug reporting system contributed to the monitoring of health status. The common elements policy outlined expectations for development of a health status monitoring system, which included a number of clinical indicators. Additional clinical indicators need to be developed. The recently implemented medical protocols should provide several. Again, clinical indicators will need to be developed across all disciplines and not just medical, nursing and psychology. With establishment of a comprehensive set of clinical indicators, the facility will need to determine how to effectively measure and capture if outcomes are being achieved. This will likely require some revision of the audit tools currently used.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The policy on minimum common elements included, in the health status monitoring requirement, some metrics for determining that interventions occurred in response to clinical indicators across the various disciplines. This appeared to be a good start in thinking how to meet this provision item. This provision item, like many others in provision H, represents a mechanism of auditing how the facility is performing. The most critical issue is to develop protocols, practices, and standards that are consistent with professional standards. When that is established, clinical indicators cited within the context of those standards are then used to measure compliance. The facility can then determine if outcomes are met. If outcomes are not met, the expectation would be to change the interventions until an acceptable outcome is achieved.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The state had not finalized the policy regarding this provision. The facility implemented a policy, based on the state draft. That policy will likely need revision as the various disciplines finalize many issues related to the actual provision of care and services.	Noncompliance

Recommendations:

1. State office and the facilities should work together to determine how they are going to address all of the seven items of this provision. Therefore, specific recommendations for each of the seven provision items are not presented here (H1 – H7).

2. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H (H1 – H7).

3. Ensure that all clinical services are addressed by the facility, not only medical activities (H1 – H7).

4. Involve the facility's QA department in the many monitoring and data tracking activities that will be required to increase the likelihood of meeting the requirements of this provision (H1 – H7).

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o SGSSLC High Risk Determination Policy dated 10/6/11 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Integrated Risk Rating Form dated 12/20/10 o DADS Quick Start for Risk Process dated 12/30/10 o DADS Risk Action Plan Form o DADS Risk Process Flow Chart o DADS Risk Guidelines date 12/20/10 o Aspiration Pneumonia/Enteral Nutrition Evaluation Form 12/29/10 o Aspiration Triggers Data Sheet o SGSSLC POI for Section I o List of serious injuries for the past six months o List of individuals with the greatest number of injuries o List of individuals seen in the ER since 11/1/10 o List of individuals admitted to the infirmary since 1/3/11 o List of individuals hospitalized since 11/1/10 o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individuals at risk for choking o List of individuals at risk for GERD o List of individuals at risk for aspiration o List of individuals at risk for weight issues o List of individuals at risk for falls o List of individuals at risk for dehydration o List of individuals at risk for osteoporosis o List of individuals at risk for constipation o List of individuals with choking incident since the last review o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals requiring mealtime assistance o List of individuals requiring enteral feeding o List of individuals who have pain, including chronic and acute o List of individuals considered missing or absent without leave o List of individuals required to have one-to-one staffing levels o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o List of top ten individuals causing peer injuries for the past six months.

	o List of Incidents and Injuries since 5/1/11 o PSPs, Risk Rating Forms, Risk Action Plans and relevant assessments for determining risk: • Individual #336, Individual #66, Individual #251, Individual #248, Individual #193, Individual #50, Individual #116, Individual #18, Individual #385, Individual #292, Individual #265, Individual #252, Individual #132, Individual #321, Individual #325, Individual #214, Individual #294, and Individual #120 <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Michael Davila, QDDP Coordinator o Michael Fletcher, QDDP Educator o John Church, POI Coordinator o Robb Weiss, Chief Psychologist <u>Observations Conducted</u>: o Observations at residences and day programs o Unit 1 Morning Meeting – 12/6/11 o Incident Management Review Team Meeting 12/6/11 and 12/7/11 o Human Rights Committee Meeting 12/7/11 o Restraint Reduction Committee 12/8/11 o Annual PSP meetings for Individual #285 and Individual #376
	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. It was updated on 11/22/11. The POI indicated that the facility had conducted a self-assessment for this provision using the statewide audit tool. Additionally, the comments section of each item of the provision included a statement regarding how the facility carried out the mandate (e.g., retrained PST on at-risk guidelines and policy). The POI indicated that findings from activities of self-assessment were used to determine the self-rating of each provision item. As noted throughout Section I, the monitoring did not find that steps implemented to comply with Section I were adequately addressing risks The facility assigned a noncompliance rating to each of the three provision items in section I. The facility acknowledged that it was in the initial stages of implementation of the new at risk process that was designed to meet the provisions of section I. The monitoring team was in agreement with these self-ratings.

	Summary of Monitor's Assessment: Some steps SGSSLC had taken towards compliance with this provision included: • All individuals had PST meetings to address their risks utilizing the new At Risk Process. • The facility began using the statewide Section I audit tool to assess compliance. • An at-risk committee was formed and staff were assigned to begin monitoring the at risk process during annual PST meetings. • PSTs were retrained on the at-risk policy and guidelines for determining risk levels. • An interdisciplinary team of discipline heads held At-Risk Oversight Modeling Sessions and provided feedback to PSTs regarding risk rating rationales. • The facility began using an interview tool to quiz direct support staff on risks for individuals who they support. • Consultation protocols were revised to ensure RN case managers notified team members of changes in health status or health management plans resulting from medical consultations. As noted throughout Section I, the monitoring team did not find that PSTs were accurately identifying risk for individuals. All staff needed to be aware of 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.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy, At Risk Individuals 006.1, required PSTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the PST meeting and the team was required to develop a plan to address risk at that time. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee when appropriate. A list of indicators for each of 21 risk areas had been identified by the state policy. Each was to be rated according to how many risk indicators applied to the individual's case. A risk level of high, moderate, or low was to be assigned for each category. Observation of annual PST meetings scheduled the week of the monitoring review showed that PSTs had just begun this new process and were still experimenting with how to integrate the new risk identification process with the new PSP development process. QDDPs were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the process appeared to be similar to the process that Health Status Teams were using during previous onsite reviews. Although, teams were beginning to engage in more in-depth discussions regarding health indicators, there was still a strong reliance on guidelines developed by the state that did not take into consideration integrated risk factors. Clinical indicators were not always available at	Noncompliance

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		meetings and, therefore, not always considered when determining health risk ratings. The facility captured data in a number of ways that should have been useful to identify risks for particular individuals, but it was not evident that the data were always being used to identify risks. The monitoring team observed the PST meeting for Individual #285. The PST did not have data or health indicators necessary to thoroughly evaluate his risks. It was noted that he was 46 pounds over his ideal weight range. He was on a low calorie diet, but the team was not sure how much weight he had lost over the past year. The dietician did not attend the PST meeting. The team did not have the information needed to make an informed decision without consultation from the dietician. It was determined that a meeting would have to be held later to get the dietician's input. The dentist was not present and had not submitted a report prior to the meeting, so team members were unsure of any supports that may be needed in regards to dental hygiene. Interrelated risk factors such as his risk for cardiac issues due to obesity were not discussed. A sample of PSPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by PSTs. The following are some examples where risks were not appropriately identified in documents reviewed. ▪ The PST for Individual #18 conservatively assigned risk ratings based on his current diagnosis and recent health incidents. He had a number of interrelated health risks. The team had determined that he was at high risk for osteoporosis due to a current diagnosis and at medium risk for falls based on a history of falls. The team rated him at low risk for fractures since he had no recent history of fractures. The team should have considered that his diagnosis of osteoporosis and history of falls placed him at risk for fractures. A plan should have been developed to reduce the likelihood of fractures occurring. ▪ Individual #120 was diagnosed with moderate to severe sleep apnea, was obese and had gained 32 pounds in the past year, refused to use his CPAP machine, had hypertension, hyperlipidemia, a family history of heart disease, and smoked. It did not appear that the PST had considered how these risk factors were interrelated to place him at a high risk in some areas. The team rated him as low risk for respiratory compromise and medium risk for weight and cardiac issues. He had a history of constipation and was taking five medications with the possible side effect of constipation. Due to concerns regarding constipation, a barium enema study was completed over a month prior to the risk discussion, but results were not available to the team. He was rated as low risk for constipation. ▪ The PST for Individual #132 rated him at low risk for choking because he had supports in place to address his risk for choking. The PST should have considered that supports were put into place because he was at risk and rated	

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		him as being at risk. His rehabilitation therapy assessment included the recommendation to considerate a moderate risk rating. ▪ The most recent rehabilitation therapy assessment for Individual #251 noted that he had a moderate risk for skin integrity due to a history of dermatitis and seborrheic keratoses. The PST rated him at low risk for skin integrity. Other risk ratings were accurate based on information provided in assessments. ▪ The PSP for Individual #294 did not document the occurrence of an integrated discussion on risks. He was rated at moderate risk for falls and low risk for fractures by his PST. His rehabilitation therapy assessment noted that he was "experiencing increasing difficulties with his safety during ambulation which may be connected to his visual deficits." He was using a gait belt for support with transfers and ambulation and a wheelchair when outside the home. His medical assessment documented six falls over the last year resulting in at least one significant injury. He was taking Zyprexa for aggression and his psychoactive medication review noted that instances of physical aggression remained constant. His PSP noted that he had a behavioral support plan, but did not include a summary of the plan. Assessments further indicated that his falls may have been due, at least in part, to challenging behaviors. He was rated low risk for challenging behaviors. His dental exam noted that he had a medium periodontal risk. His PST rated him low for dental issues. Additional examples are listed in section M5. At the annual PSP meeting for Individual #376, however, there was active and good discussion by the participating medical staff (physician assistant and psychiatrist) and nursing staff regarding fluid imbalance. As a result, the PST correctly rated the individual at high risk for this category. For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health indicators (changes in medication, results from lab work, engagement levels, mobility, etc.) • Consider and discuss the interrelatedness of risk factors in an interdisciplinary fashion. • Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. Teams were engaging in discussion regarding current medical conditions that placed individuals at obvious risks, but did not adequately address possible long term health issues. • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines.	

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		• Monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs. The facility's POI indicated that the facility had given itself a noncompliance rating for this provision. The facility was not yet in compliance with this provision of the Settlement Agreement. The facility needs to ensure that present risk assignments are reviewed for accuracy, adequate plans are in place to address all risks, and all staff are trained on plans to minimize and monitor risks.	
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 new At Risk policy required that when an individual was identified at high risk, or if referred by the PST, the PNMT or BSC was to begin an assessment within five working days if applicable to the risk category. The PNMT or BSC was required to assess, analyze results, and propose a plan for presentation to the PST within 14 working days of the completion of the plan, or sooner if indicated by risk status. As noted in section I1 above, not all risks were identified by the PST. Additionally, as noted in section F of this report, the facility did not have an effective plan for monitoring and revising supports as needed. The facility will need to have a system in place for accurately identify risks before achieving substantial compliance with I2 One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. The facility was not yet in compliance with this provision item.	Noncompliance
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,	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. It required that the PST implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the PSPs that were reviewed included general strategies to address identified risks, but again, not all risks were identified as a risk for each individual. The new policy required that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the PST in response to risk categories identified by the team. According to data provided to the monitoring team, a plan was in place to address all risks for those individuals designated as high risk or medium risk in any area. However, as noted in I1, accurate risk ratings were not necessarily being assigned, so adequate	Noncompliance

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	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.	plans were not in place for all individuals. Plans that were in place did not always include clinical indicators to be monitored to accurately determine the adequacy of the plan. For example, the Risk Action Plan for Individual #18 had a number of action steps addressing his respiratory risk including "assess respiratory status as needed." The plan did not indicate what clinical indicators should be present to warrant an assessment or what assessment results would require additional follow-up. Similarly, he had another action step to increase fluids. The plan did not indicate how much or how often fluids should be offered or how the team would assess his fluid intake for adequacy. Additionally, plans were not always integrated into PSPs or conflicted with action plans in PSPs. For example, Individual #132 had an action step in his risk action plan to taper psychoactive medications to lower the risk of side effects from polypharmacy. His PSP included an action step to continue all current medication. Individual #120 had an action step to lose weight in his risk action plan. It was not referenced in his PSP. The facility will need to ensure that all direct support staff can identify risks for individuals whom they support. Staff should be trained on providing supports that reduce risks and monitoring for additional risks factors. In informal interviews throughout the facility, it was not evident that staff had received adequate training on individual's risks. For example, two direct support staff in the home were asked why Individual #126 was wearing a helmet. Neither staff was sure what risk factors precipitated the order for a helmet. Staff could not find her individual notebook to look up her risk information. Section I audit tools completed July 2011 through September 2011 also indicated that direct support staff were not able to identify risk factors for individuals whom they support. It will be necessary for the facility to have a system in place that accurately identifies risk prior to achieving substantial compliance with I3 requirements. As noted throughout this report, intervention plans often did not provide enough information for direct support staff to consistently implement support or were not carried out as written, therefore, individuals remained at risk. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility POI indicated that the facility was not in compliance with this provision. The monitoring team agrees with that assessment.	

Recommendations:

1. The facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QDDPs should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process (I1).

2. The facility needs to ensure that present risk assignments are reviewed for accuracy

3. The facility needs to ensure that adequate plans are in place to address all risks (I1).

4. The facility needs to ensure that all staff are trained on plans to minimize and monitor risks (I1).

5. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).

6. 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 (I1, I2, I3).

7. Ensure PSTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).

8. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).

9. Implement a monitoring system to ensure that direct support staff have PSPs and other plans readily available at all times to provide necessary supports to each individual in the home (I2 and I3).

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Any policies, procedures and/or other documents addressing the use of pretreatment sedation medication o For the past six months, a list of individuals who received pretreatment sedation medication or TIVA for medical or dental procedures o For the last 10 individuals participating in psychiatry clinic who required medical/dental pretreatment sedation, a copy of the doctor's order, nurses notes, psychiatry notes associated with the incident, documentation of any PST meeting associated with the incident o Ten examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic o List of all individuals with medical/dental desensitization plans and date of implementation o Ten examples of desensitization plans (five for dental and five for medical) o Auditing/monitoring data and/or reports addressing the pretreatment sedation medication. o A description of any current process by which individuals receiving pretreatment sedation were evaluated for any needed mental health services beyond desensitization protocols o Individuals prescribed psychotropic/psychiatric medication, and for each individual: name of individual; name of prescribing psychiatrist; residence/home; psychiatric diagnoses inclusive of Axis I, Axis II, and Axis III; medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration); frequency of clinical contact (note the dates the individual was seen in the psychiatric clinic for the past six months and the purpose of this contact, for example: comprehensive psychiatric assessment, quarterly medication review, or emergency psychiatric assessment); date of the last annual BSP review; date of the last annual PSP review o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use o A list of individuals diagnosed with tardive dyskinesia, including the name of the physician who was monitoring this condition, and the date and result of the most recent monitoring scale utilized o Spreadsheet of individuals who were evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months o Documentation of in-service training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Ten examples of MOSES and DISCUS examination for 10 different individuals, including the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations o A separate list of individuals being prescribed each of the following: anti-epileptic medication

	being used as a psychotropic medication in the absence of a seizure disorder; lithium; tricyclic antidepressants; Trazodone; beta blockers being used as a psychotropic medication; Clozaril/Clozapine; Mellaril; Reglan o List of new facility admissions for the previous six months and whether a REISS screen was completed o Spreadsheet of all individuals (both new admissions and existing residents) who had a REISS screen completed in the previous 12 months o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: individual Information Sheet; Consent Section for psychotropic medication; Personal Support Plan, and PSP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refused to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attended or might attend, including any information that is routinely collected concerning the Psychiatrists' attendance at the PST, PSP, PSPA, and BSP meetings o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that related to the role of psychiatrists o A list of all psychiatrists including board status; with indication who was designated as the facility's lead psychiatrist o CVs of all psychiatrists who worked in psychiatry, including any special training such as forensics, disabilities, etc. o Letter from Abilene Psychiatric Associates dated 11/14/11 from Duane Miller, M.D. confirming psychiatric consultation for children and adolescents at SGSSLC o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and in-service training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who had a diagnosis of seizure disorder o For the past six months, minutes from the committee that addressed polypharmacy o Any quality assurance documentation regarding facility polypharmacy

	o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 <u>newly prescribed</u> psychotropic medications: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses were revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who had a psychiatric assessment per Appendix B, with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Comprehensive psychiatric evaluations per Appendix B performed in the previous six months for the following individuals: • Individual #6, Individual #11, Individual #175, Individual #216, Individual #39, Individual #330, Individual #400, Individual #186, Individual #209, Individual #41, Individual #305, and Individual #309 o Documentation of psychiatry attendance at PSP, PSPA, BSP, or PST meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months <u>Documents Requested Onsite:</u> o Dr. Mercer's documentation for psychiatry clinic, 12/05/11 regarding Individual #120, and Individual #277 o Dr. Bazzell's documentation for psychiatry clinic 12/06/11 regarding Individual #200, and Individual #132 o Dr. Mercer's documentation for psychiatry clinic 12/07/11 regarding Individual #144, and Individual #311 o These following documents for all of the individuals listed in the above three bullets and for Individual #76, Individual #48, Individual #346, Individual #243, Individual #153, Individual #104, and Individual #112 • Face Sheet • Social History (Most Current) • Annual Medical Summary and Physical Exam • Active Current Diagnoses Sheet • X-ray/Lab section (for the last six months) • Psychiatry section (for the last six months) • Neurology section (for the past year) • MOSES/DISCUS results (for the last six months) • Reiss Screen • Pharmacy section (for the last six months)

	• Consent section for psychotropic medication and Human Rights Committee Approval • Consent for pretreatment sedation • Integrated progress notes (for the last six months) • PSP and PSP addendums/reviews/annual (for the past six months) • Behavior Support Plan • Desensitization Plan • Psychological Evaluation (Most Recent) <u>Interviews and Meetings Held</u>: o Jimmy Randal Mercer, M.D., lead psychiatrist o William Earl Bazzell, M.D., facility psychiatrist o Roy Guevara, R.N., facility psychiatry nurse o Constance M. Whorton, R.N., facility psychiatry nurse o Jennifer Quisenberry, psychiatry assistant o Rebecca McKown, M.D., medical director o Rob Weiss, Psy.D., chief psychologist o Don Conoly, R.Ph., pharmacy director o Philip Rolland, Pharm. D., MHA, clinical pharmacy director o Thomas Anderson, DDS, dental director o Carly Dusek, Registered Dental Hygienist o Kim Woodard, dental assistant <u>Observations Conducted</u>: o Psychiatry clinic with Dr. Mercer for Individual #120, and Individual #277 o Psychiatry clinic with Dr. Bazzell for Individual #200, and Individual #132 o Psychiatry clinic with Dr. Mercer for Individual #144, and Individual #311 o Positive Behavior Support Program Committee o Medication Review/Polypharmacy meeting o Medical Provider Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment, the Plan of Improvement, dated 11/22/11. In addition, during the onsite review, the monitoring team reviewed the presentation book for this provision. In the POI comments section of each item of the provision, there was a summary about what tasks were completed and/or the status of each provision item. The facility indicated a self-rating of noncompliance in all subsections of provision J. The assignment of substantial compliance for J1 was given by the monitoring team (having qualified psychiatric physicians) because the psychiatrists currently providing care at the facility, were, by virtue of their board certification and/or eligibility status, and experience, qualified to provide care at the facility.

	With the exception of J1 as detailed above, the monitoring team's review of the remainder of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment. The monitoring team's review was based on observation, staff interview, and document review. The facility will need to engage in similar activities in order to conduct an adequate self-assessment. In discussions with the facility psychiatrists, the need for improved integration was noted. Most provision items in this section rely on collaboration with other disciplines. The action steps included in the POI were written to guide the department in achieving substantial compliance. Some of the actions were relevant towards achieving substantial compliance, but the facility will only achieve substantial compliance if a set of actions, such as those described in this monitoring report, are set out en banc as a system. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. The facility will benefit from the development of a peer review process for this provision of the Settlement Agreement.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, SGSSLC was found to be in noncompliance with all of the items in this provision of the Settlement Agreement, except for provision item J1. One of the psychiatrists was designated as the director of psychiatry. There had been some repositioning with respect to the psychiatric clinic staff, specifically promotion of the psychiatric assistant into the role of the Settlement Agreement Coordinator (SAC). There was appointment of a new psychiatric assistant, but this individual was charged with also helping the medical department due to staff shortage. Since the last visit, there was resignation of one of the prescribing practitioners in the psychiatry department. In an effort to provide assistance to the two full-time psychiatrists, two FTE nurses, were recently assigned to the psychiatry department and, therefore, were both learning the system and meeting the individuals enrolled in the clinic. Upon meeting with the facility psychiatry staff, the monitoring team reviewed their understanding of the psychiatric issues outlined in the Settlement Agreement. The psychiatric practitioners were encouraged to document their activities and gather supporting data to reflect the psychiatry department's progress with implementation of the provisions in section J, with the goal of the establishment of a psychiatric system that met generally accepted professional standards of care. As noted throughout the monitoring's report, there was lack of data, and when supplied, was incomplete, sometimes undated, and therefore, deemed unreliable.

	The psychiatry department at SGSSLC had seen some improvement with development of a comprehensive 90-day outline for the psychiatry review. Additionally, the clinic was organized in that the individual and staff were in attendance at clinic, the psychiatrist received clinical information during clinic, and discussions regarding the individuals were more detailed. These improvements resulted in positive changes in the process of psychiatry clinic. While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, collaboration regarding case formulation). The physician was not provided appropriate data in order to make decisions regarding pharmacology in an objective manner, and per a review of records, made medication additions or adjustments in the absence of data regarding specific clinical indicators. The staff from each discipline were aware of the challenges and the need for increased structure and integration, however, they were also aware of the psychiatric staff turnover, and history of a lack of consistent clinical resources in psychiatry, which did not lend itself to close collaboration. Further, revision concerning documentation issues via psychiatry should occur and will be discussed throughout this section of the monitoring report. The facility achieved substantial compliance in J1, however, in other areas, while isolated improvements and progress were seen, the facility staff must create a system for the provision of psychiatric services. To achieve substantial compliance with section J, to accomplish a comprehensive, collaborative, integrated psychiatric subspecialty service to for the individual and other disciplines is required.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications</u> SGSSLC had a total of 2.0 FTE (full-time equivalent) psychiatrists. Both psychiatrists who were responsible for providing psychiatric treatment were either board eligible or board certified in general psychiatry. The facility continued to provide services for minors and, therefore, the lead psychiatrist, Dr. Mercer, had discussions with a child and adolescent psychiatrist. As a result of these efforts, the facility received a letter from Duane Miller, M.D., a child and adolescent psychiatrist with Abilene Psychiatric Associates, on 11/14/11, indicating his willingness to evaluate youth from SGSSLC on a consulting basis. Since the last review, the full time family nurse practitioner resigned. Psychiatry staffing, administrative support, and the determination of required FTEs are addressed below in section J5. <u>Experience</u> Both of the psychiatrists had experience treating individuals with developmental	Substantial Compliance

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		disabilities. Dr. Miller's educational background included one year of child and adolescent training in addition to a general psychiatry residency. He had experience in working with individuals with developmental disabilities due to services provided to MHMR programs in the state of Texas. Dr. Miller's CV did not provide details in regards to his board certification status (i.e., board certified/re-certified). <u>Monitoring Team's Compliance Rating</u> Based on the qualifications of the two FTE psychiatrists at SGSSLC and the information provided per the lead psychiatrist (i.e., letter of confirmation from a child and adolescent psychiatrist) this item was rated as being in substantial compliance.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	<u>Number of Individuals Evaluated</u> At SGSSLC, 165 of the 241 individuals (68%) received psychopharmacologic intervention at the time of this onsite review. There were a limited number of evaluations completed in Appendix B format (discussed in J6). There were concerns regarding the consistency of psychiatric staffing (addressed in J5) expressed by the psychiatry team as one of the factors resulting in the insufficient number of completed evaluations. Although, there was a lot of effort placed into the improvement of the clinic process regarding psychiatric documentation, the monitoring team had difficulty determining the current diagnoses due to discrepancy in psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, PSP, PBSP). It was recognized that many of the challenges to providing care in the facility were out of the psychiatrists' control. For example, these included the lack of appropriate data, and the lack of their integration into the overall treatment program at the facility. The facility did not utilize an organized system to track diagnoses and capture diagnostic updates. For example, a numbered spreadsheet of individuals prescribed psychotropic medication with dates of clinical contact provided to the monitoring team included a "patient profile report" that did not match the diagnosis in the grid provided by psychiatry. Due to the facility not having an updated database to track these elements, the PST and monitoring team were not able to determine details of diagnostics or revision of diagnostics. For example: • The patient profile report for Individual #76 noted diagnosis of unspecified organic brain syndrome (chronic), mild mental retardation, and other unspecified nonorganic, however, the DSM-IV-TR does not list the option of assigning a diagnosis of organic brain syndrome. Additionally, there was conflicting information for the Axis I diagnosis (chronic paranoid schizophrenia) in the annual physical examination that was not listed in the patient profile report. The patient profile report did not match the Axis III diagnoses noted in the psychoactive medication review quarterly (i.e., seizure disorder,	Noncompliance

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		hypothyroidism, and sensorineural hearing loss). The summary provided different diagnoses, including Schizophrenia (undifferentiated type) and did not list seizure disorder or hypothyroidism. The psychiatrist and the PST must take medical contributors into consideration when arriving at a psychiatric diagnosis and for selection of a psychopharmacologic regimen. Additionally, an individual's mental status changes may be secondary to a medical condition. Further discussion about the review of the content of the psychiatric assessment and treatment is summarized below in J13; coordination between neurologist and psychiatrist for the use of medications, when they were prescribed for treatment of both seizures and a mental health disorder, is covered below in J15. <u>Clinical Justification</u> In order to improve documentation about evaluating and diagnosing individuals in a clinically justifiable manner, recently, the psychiatric staff designed a new form called the "psychoactive medication review quarterly." The monitoring team observed the lead psychiatrist explaining the new form to the PST in the psychiatry clinics that were held the week of the review. The monitoring team encouraged the lead psychiatrist to revise the psychiatry policy and procedure to instruct the PST about expectations of material to be presented in the psychiatry clinics per the new format. These changes represented progress, but the implementation of the proposed plan should have been a formal facility-wide process. <u>Monitoring Team's Compliance Rating</u> Based on the early stage of development for the psychiatrists to appropriately document delivery of care (i.e., new psychoactive medication review quarterly), and the lack of completion of evaluations to ensure that no individual received psychotropic medication, without having been diagnosed in a clinically justifiable manner (i.e., incompletion of the majority of Appendix B evaluations), this item was rated as being in noncompliance.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately,	<u>Treatment Program/Psychiatric Diagnosis</u> Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. While all individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the lack of clinical indicators identified for justification of psychotropic medications. The monitoring team reviewed the active positive behavior support plan (PBSP), sometimes referred to as a behavior support plan (BSP) in the sample of 16 records reviewed. All 16 individuals prescribed medication had a PBSP on file. The details of the content of the PBSPs are discussed in section K of this report.	Noncompliance

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	psychotropic medications shall not be used as punishment.	It was notable the BSP documents sometimes did not include a signature from the treating psychiatrist, yet medication regimen, medication side effects, and medication changes were described in detail in the BSP. Although it was good to see this information in the BSP, it must be developed in consultation or collaboration with the individual's prescribing psychiatrist, and appropriately included in the comprehensive psychiatric assessment/quarterly psychiatric reviews. It will be imperative that psychiatry and psychology formulate a cohesive diagnostic summary for each individual. <u>Emergency use of psychotropic medication and pro re nata (PRN)</u>: There was no indication that psychotropic medication was used as punishment. There were several individuals prescribed PRN psychotropic medications at SGSSLC. For a number of these individuals, the intent of the use of PRN medication at SGSSLC was reported to be to encourage the individual to learn how to acknowledge when he or she needed something to help him or her, and to give the individual responsibility to request the medication. Although it is reasonable to consider a PRN protocol related to psychiatric care, to treat the occasional exacerbation of a psychiatric disturbance, SGSSLC will need to (a) provide staff training in regards to when it would be appropriate for staff to initiate the administration of a psychotropic PRN medication (this is very important), (b) develop policy and procedure, (c) work with state office regarding approval, and (d) evaluate the implementation and outcome on a frequent and individualized basis. There are many considerations in utilizing this type of medication approach. Consider, for example, that if the individual does not have the capacity to consent to the PRN administration and/or if staff ever prompt the individual to request a PRN psychotropic (when the individual did not initiate the request), then it might appear that the medications were being used for the purpose of staff convenience or as a substitute for a treatment program. Further, the monitoring team recommended that, if the facility elected to continue PRN use of psychotropic medication, the tracking of PRN use must be reported just as closely as is the emergency use of psychotropic medication. For example, the list provided to the monitoring team regarding individuals prescribed benzodiazepines did not include Individual #346, yet he was prescribed the benzodiazepine Ativan up to 36 mg/day PRN, (when the maximum recommended dose of Ativan is 10 mg/day). Staff reported that he routinely received Ativan 12 mg/day "per his request," yet this individual's name was not listed on the benzodiazepine list. A pro re nata medication, by definition, in medical practice, was never intended to be a maintenance drug. Further, pro re nata must never exceed a prescribed daily regimen. If the individual took medication, such as an agent with addictive qualities consistently, then decided not to take the medication (e.g., Ativan), he or she could be subjected to experience withdrawal symptomatology, such as	

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		a possible seizure from the abrupt discontinuation of the high dosage of the benzodiazepine. Also, if the individual was routinely taking the PRN, he or she might subjectively experience other symptoms, such as anxiety, if he or she did not take the agent. The team (or the individual) might not be able to determine the etiology of the presenting symptoms. This type of practice pattern did not meet generally accepted professional standards of care. If an individual routinely takes a medication, it should be prescribed as such, particularly with the complex side effects associated with a psychopharmacological regimen solo and in combination with other medications prescribed for medical purposes and/or pretreatment sedation. A PRN was a prescribed medication, so it must be included in the count of psychotropic medication. The topic of PRN psychotropic medication is further addressed below in J13. The monitoring team was provided two different sets of data regarding utilization of chemical restraints that were not consistent. For example, two separate documents did not capture the same information, though it appeared they were reporting on the same information. • The list provided to the monitoring team prior to the onsite review regarding individuals requiring chemical restraint in the last six months showed 87 incidents, with dates of incidents ranging from 5/29/11 to 10/31/11. • The monitoring team obtained information from the psychiatry department and was informed there were 148 incidents of chemical restraint for the time period 6/1/11 to 11/30/11. • Last reporting period, the facility utilized 76 instances of "Emergency Psychotropic Medication" (intramuscular or oral) for aggression towards staff and/or peer(s), property destruction, agitation, and self-injurious behavior. For this report, the monitoring team reviewed the information described in the first bullet above. The 87 incidents involved 31 different individuals with one receiving 14 of the chemical restraints (Individual #116). Unfortunately, she also received PRN medication (i.e., Ativan) when she requested the medication (even though staff informed the monitoring team that she did not have the capacity to provide such informed consent). Staff stated that there were occasions when they prompted individual #116 to take the PRN, "remind her it's there," as opposed to the original intent of the agent being utilized upon the individual's request (though this might be an appropriate skill for her to develop; if so it should have been a part of the PSP process, developed in collaboration with psychology staff and with the staff who develop and manage skill acquisition programming).	

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		Additionally, the DADS statewide policy and procedures for psychiatry services dated 8/30/11 noted "prescription of psychotropic medications must comply with all relevant ICFMR conditions of participation" which do not permit "standing or as needed programs to control inappropriate behavior." In the instance of Individual #116, the practice pattern for this case appeared to be more in line with a chemical restraint because she could not comprehend the consent process. Caution was advised to carefully monitor target symptoms, vital signs, and staffing practice to prohibit the PRN becoming an aid for staff convenience when she was experiencing some difficulties. Any restrictive intervention should be approved by the PST and included in the active treatment program to ensure justification of such usage. The monitoring team was informed that the lead psychiatrist was not a member of the committee that reviewed chemical and protective supports. There was confusion and tension among various disciplines including psychiatry, primary care physicians, pharmacy, and nursing staff about who were considered essential staff to review the most restrictive interventions for individuals at SGSSLC (i.e., chemical restraints) and elements to collect for reporting and monitoring. <u>Monitoring Team's Compliance Rating</u> Based on the inconsistent and therefore somewhat suspect data provided to the monitoring team regarding the emergency and PRN use of psychotropic medication, making it difficult to determine if progress (i.e., medication being used as a substitute for a treatment program) was occurring in this area, this item was rated as being in noncompliance.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored	<u>Extent of Pretreatment Sedation</u> The document provided to the monitoring team did not provide the information required for tabulating the extent of pretreatment sedation. The coversheet of the pre-visit document (description of evidence gathered) noted pretreatment sedation <u>of</u> TIVA instead of collecting data for both pretreatment sedation <u>or</u> TIVA. • There was a numbered, alphabetized list of 23 uses for the past six months, with the name of the individual and type of sedation predominantly focused on "general anesthesia," with name, dosage, and route of medication. • The facility provided two separate lists, one with another 52 individuals, but some names were on both of these lists. • During a meeting with the psychiatry team the week of the onsite visit, it was reported there were 28 uses of pretreatment sedation between 6/1/11-11/30/11. The number of uses occurred for a total of 21 individuals, with nine of those during dental clinic.	Noncompliance

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	and assessed, including for side effects.	In summary, in order to evaluate the extent of pretreatment sedation utilized at SGSSLC, the calculation should include one comprehensive list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures that includes: individual's name, designation of whether it was medical or dental pretreatment sedation, date the pretreatment sedation was administered, name, dosage, and route of the medication, and date of PSP that documents review to minimize the need for the use of pretreatment sedation medication. Of the 19 individuals listed that received general anesthesia/oral sedation for the past six months, 14 (73%) were enrolled in the psychiatric clinic and eight (42%) received a routine dosage of a benzodiazepine. The monitoring team requested, prior to the onsite visit, information about the duration of benzodiazepine use for the individuals at SGSSLC, however, this pertinent information was not provided. The eight individuals were Individual #66, Individual #385, Individual #18, Individual #235, Individual #116, Individual #313, Individual #353, and Individual #137. Individuals who were prescribed benzodiazepines were subjected to potential drug-drug interactions when they received similar medications for medical or dental procedures. Of further concern, Individual #116 was also prescribed PRN benzodiazepine, per her request (see J3 above). Interdisciplinary Coordination Interviews with the dental department staff, psychology, and psychiatry revealed there had been lack of communication between the departments since the last review due to the resignation of the dental hygienist in June 2011. The monitoring team noticed that most of the referrals from the dental department requesting desensitization assessment for individuals served in the dental clinic were similarly dated 10/11/11, instead of varied dates that would be representative of timely clinical intervention. The dental staff noted this delay in request was attributed to staff shortage. The department recently hired a registered dental hygienist (on 10/17/11), but will lose another staff member, the dental assistant, in March of 2012, due to her retirement. The psychiatry staff made some progress with this provision due to the completion of pretreatment sedation notification to exchange information with dental/nursing and psychology addressing whether there was any contraindication to using the medication administered for the procedure. If so, the psychiatrist contacted the RN Nurse Case Manager and provided a new order. Desensitization Protocols A list of all individuals with medical/dental desensitization plans and date of implementation were requested. The monitoring team was provided with a document that was not dated, not titled, did not specify whether the individual had a medical or dental plan, and only listed a date of implementation for eight individuals out the 61	

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		names provided. It was not clear if these 61 individuals had been referred for the determination of whether they could benefit from a protocol. At the time of the last monitoring visit, there were a total of five completed desensitization plans at SGSSLC. These were plans for Individual #7, Individual #217, Individual #130, Individual #198, and Individual #18. This visit, a request for 10 examples of desensitization plans (five for dental and five for medical), noted the completion of a dental desensitization assessment form and/or systematic desensitization for dental treatment for the following: Individual #385 (10/19/11), Individual #261 (9/16/11), Individual #201 (9/1/11), Individual #389 (5/26/11), Individual #217 (4/22/11), and Individual #130 (1/10/11). <u>Monitoring After Pretreatment Sedation</u> A review of provided documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented assessment of the individual and vital signs. <u>Monitoring Team's Compliance Rating</u> This item will remain in noncompliance because further effort must be made with respect to the interdisciplinary review of pretreatment sedation and development of desensitization protocols. Plans must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	<u>Psychiatry Staffing</u> More than 68% of the census received psychopharmacologic intervention requiring psychiatric services at SGSSLC as of 12/15/11. The lead psychiatrist, a board certified general psychiatrist, provided an overview of the psychiatric coverage. Last review there were three FTE psychiatric practitioners providing services at the facility, however, due to the resignation of the full time family nurse practitioner in May of 2011, there were now only two FTE psychiatric physicians providing services at the facility. Each of these psychiatrists worked five days per week, a minimum of eight hours each day, and was available after hours via telephone consultation. Recently two registered nurses (RNs) were delegated to work full-time in the psychiatry clinic to assist each psychiatrist with making rounds and gathering pertinent information for quarterly reviews and Appendix B comprehensive evaluations. The two nurses joined the psychiatric team in October 2011. During the interview with the monitoring team they expressed a common goal inclusive of a commitment to improvement of clinical documentation, continuity of care with other disciplines, and facilitation of	Noncompliance

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		integration of services for the individuals served at SGSSLC. The facility reported that there were "currently no contracted psychiatrists." This information, however, was not consistent with another document listing one of the psychiatrists as both an employee and a contract staff. It would be helpful to provide contracts of all staff assigned to the psychiatry clinic including both employee and contractual appointments. As discussed in J1, the monitoring team was informed there had been discussions with a child and adolescent psychiatrist to obtain subspecialty consultation because SGSSLC would continue to provide services for minors. There were seven individuals younger than 18 years of age who were receiving psychiatric services, but not from a child and adolescent psychiatrist, or under supplemental consultation to the general psychiatrist from a child and adolescent psychiatrist. The lead psychiatrist was board certified in general psychiatry. He told the monitoring team that he had prior experience in providing care for adolescents, individuals with forensic issues, and individuals with developmental disabilities. Moreover, there had been progress in seeking consultation with a child and adolescent psychiatrist as noted 11/14/11 in correspondence from Dr. Miller to Dr. Mercer indicating "we should be able to see them within a day and certainly if you have anything more immediate, if you will call me, we will make arrangements for a more immediate time." <u>Administrative Support</u> Since the last review, the psychiatric assistant was promoted to the role of the SAC. The psychiatry department hired a new psychiatric assistant that worked diligently to collect and organize the data that were requested by the monitoring team, however, she was also assigned the completion of tasks for other sections (i.e., G, L, and N) due to staff shortage. There was a position available for a "medical secretary" to provide clerical support, however, this position was vacant. It was not surprising to find that the psychiatric assistant, although eager to provide the monitoring team with requested information, was overwhelmed by her work assignments that were not related to her role as the psychiatric assistant. Further, the expected role of the psychiatry assistant was not clear to the monitoring team. This individual had the capacity to facilitate the psychiatric clinic process in a clinical as well as an administrative function, but during this visit, appeared to function merely as clerical support. The lead psychiatrist informed the monitoring team that workload indicators would be developed to determine optimal utilization of present staffing. <u>Determination of Required FTEs</u> The calculated requirement provided by the SGSSLC's psychiatric staff for improved coordination of psychiatric treatment with primary care, neurology, other medical	

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		consultants, pharmacy, and psychology, was a minimum of 3.0 FTE prescribing psychiatric practitioners to ensure the provision of services. The lead psychiatrist indicated the number of hours for the conduct of the psychiatry clinic were developed to take into account not only clinical responsibility, but also documentation of delivered care such as quarterly reviews and Appendix B comprehensive evaluations, and required meeting time (e.g., physician's meetings, behavior support planning, emergency PSP attendance, discussions with nursing staff, call responsibility, and participation in polypharmacy meetings). The facility had two FTE prescribing psychiatric practitioners at the time of the site visit. Overall, SGSSLC had done an adequate job in assessing the amount of psychiatric FTEs required. <u>Monitoring Team's Compliance Rating</u> The facility had inconsistent psychiatric staffing that led to disruption in the team building process. The facility was in the process of securing services of a child and adolescent psychiatrist to provide consultation to the facility. Based on this and the insufficient number of prescribing psychiatric practitioners to ensure the provisions of services, this item was rated as being in noncompliance.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>Appendix B Evaluations Completed</u> SGSSLC psychiatry staff reported a total of 16 individuals had psychiatric evaluations performed according to Appendix B. Given that 165 individuals received treatment via psychiatry clinic, 90% of the individuals still required a comprehensive psychiatric assessment. At the time of the last monitoring visit, only eight initial psychiatric evaluations had been completed for the individuals enrolled in psychiatric clinic. A document submitted prior to the onsite review listed 12 individuals that had a psychiatric assessment completed per Appendix B, with dates of assessment from 2/15/11-10/21/11. A sample of Appendix B style evaluations were reviewed for the following 12 individuals: Individual #6, Individual #11, Individual #175, Individual #216, Individual #39, Individual #330, Individual #400, Individual #186, Individual #209, Individual #41, Individual #305, and Individual #309. All of the evaluations provided to the monitoring team were completed by the lead psychiatrist, yet there were noticeable variations in the content and numbered outline in which the document was completed. For example: • Individual #11's evaluation listed one of the first categories as "VII Developmental History" with the next section being "IV Family History," however, there was another "IV" category for Medical History. The monitoring team had difficulty understanding the reasons for such variation in the template when one psychiatrist completed all of these evaluations, to date, at SGSSLC.	Noncompliance

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		• Individual #175 had an initial psychiatric assessment that did not have a numeral system and also had a different outline from Individual #11. The difference in content and quality between the Appendix B evaluations may be secondary to various team members completing different sections instead of this being the sole responsibility of the psychiatrist. This will be furthered addressed in the recommendations. An Appendix B evaluation for Individual #6 was provided to the monitoring team as one of the examples for the review of this provision item. While the content of the template was addressed immediately above, and while the evaluations showed an improvement in documentation, there were some sections that required attention. • The psychiatrist adequately completed the assessment, yet further information should be documented to guide the team in regards to diagnostic clarification and selection of an evidence-based treatment plan. For instance, the psychiatrist provided pertinent information in the case formulation indicating uncertainty about the diagnoses as follows: "all of this could just be behavioral. Coming out of the environment that she had this is probably learned behavior and that her way of either protecting herself or trying to get what she wants. We will continue with these medications at present at some point look at taking her off of Thorazine and Concerta." • Individual #6 received a sedating antipsychotic three times daily for "agitation," as well as a sedating antipsychotic "PRN for severe agitation," in addition to Concerta for "ADHD," yet this was not listed in the five axes • The psychiatrist should list a rule out diagnosis and then recommend for the team to gather data. This process would facilitate determination of whether or not the individual had a diagnosis (i.e., Attention Deficit with Hyperactivity) in order to justify continued use of medication (i.e., Concerta). Instead, the plan was very general, such as "we will continue with the medications…and see how well she functions on the home…I really would like to see how well she could function off medications and hopefully over the time that she is here we will be able to try that." • If the psychiatrist and the PST determined that Concerta was not indicated and did not agree with a previous diagnosis, then the psychiatrist should summarize this information clearly for the team and establish timelines of the medication taper to discontinuation if not supported by a DSM IV-TR diagnosis. The team would preferably make one medication change at a time regarding simplification of the individual's medication in order to monitor the target symptoms that were selected by the psychiatrist and the team pertinent to the individual.	

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		In summary, instruction in the treatment recommendations must include non-pharmacologic intervention and pharmacologic intervention as summarized in Appendix B. The psychiatrist must guide the PST in a detailed fashion about intention of each medication and what to monitor in order to determine medication efficacy in an evidence-based manner to avoid the use of polypharmacy unnecessarily and to minimize potential drug-drug interactions. The psychiatrist should routinely list medical information for every psychiatric consult. In the physical exam section, vital signs inclusive of orthostatic vitals (i.e., BP and pulse) and temperature, weight, and weight range must be included in the report. The ECG result (current and/or prior reading) obtained must also be included in the report. Other medical data should be included, such as labs, the results of urine drug screen, chemistry profile, lipids, thyroid function test, etc. If this information were not available to the psychiatrist at the time of the initial comprehensive evaluation, then the psychiatrist's order to obtain the necessary work-up would be reflected in the treatment recommendations. All of the current medications and dosage, inclusive of PRNs, should be listed. <u>Monitoring Team's Compliance Rating</u> The data indicated an average of one to two comprehensive assessments, as described in Appendix B were completed per month. The monitoring team reviewed this rate with the psychiatry team and alerted them that it would take nine more years to complete the remainder of the Appendix B evaluations, without any additional admissions to the facility. Given the remaining number of comprehensive psychiatric assessments this provision will remain in noncompliance.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified	<u>Reiss Screen Upon Admission</u> The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at SGSSLC, only for those who did not have a current psychiatric assessment. The data presented to the monitoring team for this provision were unreliable. • The facility had 14 new admissions for the previous six months with 50% of these individuals being administered a Reiss screen (based on information provided to the monitoring team). • The psychiatry department documented numerous dates that they contacted the psychology department in order to obtain a Reiss Screen for the seven individuals. • The chief psychologist stated the Reiss Screens were completed for all the new admissions to SGSSLC within the first 30 days. • The monitoring team received an additional list dated 6/1/11-11/30/11.	Noncompliance

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	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.	According to this roster, there were 12 new admissions with 10 of these individuals receiving a screen. Individual #400 did not receive a Reiss until greater than two months after his admission. Fortunately, this individual received a comprehensive psychiatric evaluation within 24 hours of admission. Individual #11, admitted in September of 2011, did not receive a screen, yet received an evaluation. Likewise, Individual #363, admitted in October of 2011, did not receive a screen, but was enrolled in psychiatry clinic. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> The psychiatry and psychology department were in the initial stages of addressing this provision and were struggling with the intent for the administration of the screen. For example, if there was a current psychiatric assessment, the psychology department also obtained a Reiss Screen for those residing at the facility. The reason for completing such screens was not clear to the monitoring team and was not attributed to a change in the individual's status. This process placed undue burden on the psychology department. Further, some individuals were referred for a Reiss screen, but there was no indication as to what change in status had occurred that resulted in this referral. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> Individuals that were referred for an evaluation due to the "score equated high" on the screen were either already enrolled in psychiatry clinic or were evaluated by psychiatry and deemed not in need of psychiatry services. Examples included, but were not limited to, the following: Individual #230 (already enrolled in psychiatry clinic), Individual #365 (no psychiatry services needed), and Individual #339 (no services needed). Individual #234 was referred to psychiatry due to elevated score, but "n/a" was assigned in the column for date of the comprehensive psychiatric evaluation, therefore, an unclear entry. <u>Monitoring Team's Compliance Rating</u> Given the challenges with the unreliable data presentation, individuals not being screened upon admission, and all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication not receiving a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner, this provision remained in noncompliance.	
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	<u>Policy and Procedure</u> The SSLC statewide policy and procedure dated 8/30/11 for psychiatry services had a title of "Integrated Care" summarizing that each state center must "develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation." There were, however, no specific procedural elements denoted for the PST to follow, therefore, there	Noncompliance

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	treatments with behavioral and other interventions through combined assessment and case formulation.	were no written documents to guide the development and implementation of such a system to address this provision. The SGSSLC facility-specific policy and procedure dated 8/25/11 regarding psychiatric services did not address combined assessment and case formulation. Interdisciplinary Collaboration Efforts The monitoring team observed three separate psychiatric clinics held with three different PSTs. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, PST members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines, but psychology did not consistently provide data of the essential target symptoms that were deemed necessary for monitoring of the current psychiatric diagnosis. Further, as noted above, depending on what document was reviewed, there were varied diagnoses assigned. Medication decisions made during clinic observations conducted during this onsite review were based on lengthy (minimum 30 minute) observations/interactions with the individuals, as well as the review of information provided during the time of the clinic. In the three clinic observations, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them, and discussed the plan, if any, for changes to the medication regimen. This was good to see and showed continued progress. A review of the psychiatric and psychological documentation, however, indicated inadequacies in combined case formulations. This type of collaboration should be evident in psychiatry clinic, the psychiatric treatment plan, psychiatric assessments, the PSP process, the PBSP process, and, hopefully, with other interventions and disciplines (e.g., speech and language, OT/PT, medical). Interviews conducted during this monitoring review revealed that combined case assessments and formulations had been inconsistently occurring since the last review. There were, however, the beginnings of integration between psychiatry and psychology, specifically the reported attempts by psychiatry to attend some PSP meetings, and there were also opportunities for interaction during psychiatry clinic with the psychologist and other disciplines. Integration of Treatment Efforts The psychiatry team expressed concern that they were not considered by other SGSSLC disciplines to be part of the PST. There was discussion about the definition of the PST, with variation identified, depending on the policy, and state versus facility-specific. The psychiatric clinicians were perplexed about the reasons that psychiatry had not been	

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		considered part of the functioning treatment team, wondering if perhaps this was due to problems in establishing a working relationship due to the frequency of staff turnover. For example, turnover resulted in the reduction of prescribing psychiatric practitioners, contributing to the lack of completion of evaluations that included combined assessment and case formulation. On the other hand, there might have been confusion about what is considered to be a core PST in the ICFMR regulations versus what is considered to be an interdisciplinary PST by the Settlement Agreement. Either way, a case formulation should provide information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. Coordination of Behavioral and Pharmacological Treatments When there is lack of integration of the PST, psychiatry and psychology will not be (and at SGSSLC were not) aligned. As a result, for example, they did not identify similar content and there were differences in the identification of the target symptoms (psychiatry) and target behaviors (psychology) that would be monitored. This continued to be problematic whereby the target symptoms identified were not applicable to the assigned diagnosis. These differences impacted the overall review of efficacy of pharmacological treatment and also altered the determination of specific behavioral and other interventions specific to the individual's needs. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was minimal discussion during the psychiatric clinics regarding results of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. For example, the Brief Psychiatry Rating Scales (BPRS) were not reviewed during the clinic observation until the monitoring team prompted the PST to discuss any objective assessments obtained. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. To reiterate, one area of integration that required attention was regarding the use of data. Both psychiatry and psychology staff voiced concern regarding the accuracy of the choice of clinical indicators for the individual. It was also notable that graphs of data presented to the physician did not, but should include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies). Monitoring Team's Compliance Rating	

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		• Due to the lack of psychiatry being an integral part of the PST, the criteria for implementing the content of this provision were not achieved. This provision remained in noncompliance.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	<u>Psychiatry Participation in BSP and other PST activities</u> Per interviews with the psychiatry staff, the prescribing psychiatric practitioner did not routinely attend meetings regarding behavioral support planning for individuals assigned to their caseloads, and were not consistently involved in the development of the plans. This arrangement negatively affected the decision making progress in regards to diagnostics, indications for utilization of psychotropic medication, and/or recommendations of other less intrusive measures. The psychiatrists stated a willingness to become more involved, but indicated that a lack of clinical time and requirements of their attendance at other meetings would likely make this impossible. The lead psychiatrist, however, was the psychiatric representative at the Positive Behavior Support Program (PBSP) committee meetings. This was good to see, but did not address the requirement of this provision item. It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. There was, however, progress in the psychiatrists' participation in PST meetings. There were 53 entries documenting the psychiatrists' involvement in annual reviews, initial, and updated PST meetings. The monitoring team was provided the signature page of 20 annual PSPs for different individuals receiving psychiatric services at SGSSLC, reflecting the psychiatrist's involvement with the development of the plan (and as observed at the PSP meeting for Individual #376). <u>Treatment via Behavioral, Pharmacology, or other Interventions (in combination or alone)</u> The following example highlighted the continued problems of poor communication amongst the team members and, therefore, the existence of an inadequate development of the treatment plan by the PST. • PSP Addendum dated 10/14/11 for Individual #104 did not include a psychiatrist's signature. The BSP section of the addendum stated that Individual #104 had a severe level of intellectual disability (i.e., did not have the capacity to	Noncompliance

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		consent to treatment) and yet he was allowed to sign for IV anesthesia on 10/3/11, as summarized in the PSP Addendum (held to discuss dental sedation). The treating psychiatrist and Individual #104 were not present for the pretreatment sedation meeting. • In regards to addressing side effects, a psychiatrist reviewed Individual #104's case and determined "persistent" Tardive Dyskinesia (8/24/11 per DISCUS) and less than three months later, the other staff noted no TD (11/15/11). • "Current medications" only noted "Zyprexa 30 mg HS," but he also received an AED regimen for his seizure disorder, medication for hypothyroidism, and Geodon (Ziprasidone 20 mg Intramuscular PRN for agitation or aggression). • There was no noted psychotic disorder on Axis I, however the medication consent dated 7/15/11 regarding utilization of the antipsychotic, Geodon, listed the expected benefit of "a decrease in hallucinations, delusions, and or paranoia." Axis I diagnosis was Disruptive Behavior Disorder and Neuroleptic Induced Movement Disorder. <u>PSP Specification of Non-Pharmacological Treatment, Interventions, or Supports (with use of psychotropic medication)</u> The psychiatrists were aware that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not necessarily chosen due to the identified psychiatric diagnosis. The psychiatrists attempted to give feedback to the psychology staff during the psychiatry clinic, but the psychology representative during one of the clinics observed, was substituting for another psychologist. <u>Monitoring Team's Compliance Rating</u> To meet the requirements of this provision item, there needs to be an indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. As stated in other sections of this report regarding provision J, psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance.	
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	<u>Policy and Procedure</u> A review of DADS policy and procedure entitled "Psychiatry Services," dated 8/30/11, noted that state center responsibilities included that the psychiatrist "must solicit input from and discuss with the PST any proposed treatment with psychotropic medication…must determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially	Noncompliance

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	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.	more dangerous than the medications." As indicated below, this was not being implemented at SGSSLC. <u>Quality of Risk-Benefit Analysis</u> Comments regarding the risk/benefit analysis for treatment with psychotropic medications and restrictive programming were included in the positive behavioral support plans. These were, however, authored by psychology staff and, therefore, did not satisfy the requirements of this provision item or meet generally accepted professional standards of care. The monitoring team was present for the BTC committee, along with the chief psychologist and lead psychiatrist, and stressed the importance of the psychiatrist and the PST reviewing the content of this provision and determining the most appropriate way to address the risk-benefit analysis because it was not adequate to have medications outlined in the BSP without the prescribing physician being the author of those relevant portions of the BSP. The BTC committee agreed to consider alternative ways of addressing risk-benefit analysis of medications, such as in a separate document, authored by the prescribing practitioner. Per staff interview and record review, there had been minimal change in practice with regard to this provision in the intervening period since the previous monitoring review. A current review of the records of 16 individuals who were prescribed various psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. <u>Observation of the Psychiatry Clinics</u> During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed some of the laboratory findings with the PST, but did not thoroughly outline findings in the form of a risk/benefit analysis. The structure of the new quarterly psychiatry form utilized at SGSSLC, however, may facilitate this process in the future. The development of the risk/benefit analysis could be undertaken during psychiatry clinic. The team should consider reviewing this type of information together via a projector/screen and typing the information <u>during</u> the clinic process. The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the PST by holding lengthier clinics (i.e., 45-60 minutes per individual consult), access to equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time would be necessary to set up the shell of the document. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. The documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits	

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		could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. <u>Human Rights Committee Review</u> A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the PST, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). The following example for Individual #11, submitted to HRC Committee on 9/23/11, did not reveal sufficient documentation by the psychiatric physician of an individualized specific risk/benefit analysis, yet even so, it was approved. Individual #11 was prescribed Strattera (Atomoxetine) with the description of potential adverse or side effects for this male that included menstrual cycle changes. • The disclosure of alternative treatments included the use of another psychoactive medication, which would most likely have similar, "if not worse, side effects." • The possible consequences of refusal to consent to the use of Strattera were "continued aggression, and possible harm to self or others," yet the medication was prescribed to treat Attention Deficit Hyperactivity Disorder. Clearly these descriptors presented to HRC did not meet generally accepted professional standards of care. Regarding the same Individual #11, consent for Risperdal (Risperidone) was also submitted to HRC on 9/23/11. In this document, instead of using the correct name of the individual, there were two different names, other than the individual's name, used throughout the consent (i.e., one incorrect name was listed in the description of expected benefits, another incorrect name was listed in the disclosure of any standard alternative treatments, and the wrong name was listed incorrectly again in the "offer to respond to questions concerning the use of proposed psychoactive medication"). Members in attendance at the HRC meeting and the assigned guardian must not have read the content of the consent for a medication, one that has the potential for serious side effects, such as tardive dyskinesia; neuroleptic malignant syndrome; QTc prolongation of the ECG, and diabetes mellitus). Further, this individual did not have the capacity to consent to such medication. <u>Monitoring Team's Compliance Rating</u> There was a need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. The input of the	

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		psychiatrist and various disciplines must occur and be documented in order for the facility to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Facility-Level Review System The lead psychiatrist stated that there was a regularly scheduled meeting, at least monthly, to review those individuals receiving polypharmacy. There were, however, no minutes available for the polypharmacy committee for the past six months and no quality assurance documentation regarding facility polypharmacy. The POI had an entry dated 11/16/11 that the polypharmacy meetings were "captured in the medication review meeting each Thursday." The monitoring team was not provided minutes from the medication review meetings. It was imperative for the facility to have detailed data of a facility-level review system to address the prescription of intraclass and interclass polypharmacy. Review of Polypharmacy Data No summarized data, to show facility-level utilization of psychotropic medication, were presented to the monitoring team,. The spreadsheet of individuals listed had categories that were not readable due to a dark highlight. For example, Individual #309 had a medication listed under the antidepressant and antipsychotic category, but the actual names of the medications were in a black highlight with the majority not readable. There were 62 individuals that were noted to receive at least three psychotropic medications (interclass), but the names for those prescribed intraclass were not apparent. Regarding the list of interclass medications, one individual received six, five individuals received five, 17 received four, and 39 received three medications, prescribed by psychiatry. Review of Polypharmacy Justifications The intention of the facility-level review was to ensure that the uses of psychotropic medications were clinically justified, and that medications that were not clinically justified were eliminated. The monitoring team attended the medication review committee/polypharmacy meeting. The meeting was well attended and included representatives from various disciplines inclusive of pharmacy, psychiatry, medical, and nursing. There was not a psychology representative, therefore, the monitoring team proposed for the committee to revise the necessary disciplines' attendance. For example, during the meeting there was discussion of environmental contributors leading to an individual having difficulties that warranted revision of his plan, instead of total reliance on medication. This individual had difficulties while on home visits, refused medications (e.g., seizure and psychopharmacological agents), had difficulties upon return to the facility, and as a result, required a polypharmacy regimen. There was robust discussion and the group was generally receptive to feedback to enhance the quality of information gathered in this forum (e.g., rationale for the utilization of a particular regimen consistent with DSM-IV-TR terminology and evidence-based practice).	Noncompliance

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		The practice of PRN medication use, whereby individuals request their own medication, was discussed (also see J3 above). Once the issue of consent was raised, the lead psychiatrist said that PRN usage would be further reviewed. The use of PRN medication, especially if received in a routine fashion such as one individual that reportedly received Ativan 12 mg/day, must be included in the psychotropic medication count, with drug-drug interactions considered, and implementation of medical/nursing monitoring similar to pretreatment sedation. The purpose of the medication review/polypharmacy committee meeting was discussion of individuals who were on multiple medications in order to "analyze/reduce the amount of medication and/or the justification for the polypharmacy." There was not a synopsis provided to the monitoring team regarding the percentage of those receiving psychotropic medication that were prescribed a polypharmacy regimen. Instead, there was an individualized undated listing (e.g., Individual #243 received six psychotropic medications, Individual #215 received five medications). For future onsite reviews, it would be helpful for the facility polypharmacy review to take place at the beginning of the week so that the monitoring team can provide feedback throughout the remainder of the week. There was also confusion among the staff at SGSSLC in regards to what was supposed to be monitored and reviewed in the medication review committee versus the polypharmacy committee and how the members of various committees were selected. For example, the psychiatrist was not a member of a vital committee that reviewed chemical restraint information for psychiatric purposes. The clinical indicators outlined for the review were not reflective of evidence-based practice for evaluating efficacy of the selected medication regimen. For example, the "justification information" summary in the document request frequently noted "medication being used to treat different symptom." For example, Individual #175 received five psychotropic medications with indication for impulsive behavior, mood swings, depression, mood and sleep, and psychosis, but on a separate page, the summary for justification was "medication being used to treat different symptom." Thus, the team could not accurately detect if the medications were effective for the identified psychiatric illness. This type of example exemplified most of the data presented. Documentation of minutes from the meetings addressing polypharmacy was not available, thus, evidence of the facility's progress in decreasing unnecessary psychopharmacologic intervention could not be not calculated. At the time of the last onsite review, the POI had an entry 4/12/11 indicating that there were "questionable data" regarding the polypharmacy database and that the facility had experienced several	

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		changes in the pharmacy department staffing. Hopefully, this issue will be resolved with the hiring of the new clinical pharmacist. Additionally, the polypharmacy committee must be aware of all medications that the individual was prescribed in order to further determine the next plan of action, though it was appropriate that all medications were not specifically included in the count. Individuals with a psychiatric illness, particularly those with a neurological condition, such as a seizure disorder, must be analyzed in view of their overall medical condition in regards to potential drug-drug interactions (see J15). Additionally, case review and integration of data for individuals prescribed pretreatment sedation and polypharmacy were imperative in order to avoid further drug-drug interactions. Thus, the importance of ongoing monitoring for side effects, adverse drug reactions, and quarterly drug regimen reviews remained very important (see section N). As was discussed during the onsite review, in some cases, prescribed treatment with multiple medications may be absolutely appropriate and indicated for some individuals. This, however, should be the exception and not the standard approach of the facility. The prescriber must justify the clinical hypothesis guiding said treatment. Additional information would be necessary in order to adequately justify the use of polypharmacy. The psychiatry staff was able to provide the monitoring team some examples that would warrant the consideration of medication reduction. For example, Individual #56 received three medications and was noted to be "in process of tapering Risperidone." The facility was receptive to minimize polypharmacy, but had difficulties maintaining a consistent database of tracking this information for a systemic level of review. <u>Monitoring Team's Compliance Rating</u> This provision remained in noncompliance due to lack of an established system level review (i.e., reliable and consistent documentation of the findings of polypharmacy). The evidence of the facility's progress in decreasing possible unnecessary psychopharmacologic intervention was not calculated. These findings were consistent with last review of "questionable data" regarding the polypharmacy database as the facility had experienced several changes in the pharmacy department staffing.	
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	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> The facility provided a spreadsheet of individuals with a single date for both the last MOSES and DISCUS, but did not give the dates of completion for the last six months, as requested. Additionally, only the score of the DISCUS was provided, not of the MOSES. Therefore, the system review of tracking completion and scoring of the standard assessment tools were not available. • Individual #310 (9/7/11 DISCUS score =10) was administered MOSES on	Noncompliance

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	psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	9/7/11, but the score was not noted • Individual #130 (10/6/11 DISCUS score =8) was administered MOSES on 10/6/11, but the score was not noted. Four individuals were prescribed Reglan (Metoclopramide), but only two of them were screened for dyskinesia via the DISCUS. Individuals receiving Reglan must receive routine screening similar to those prescribed neuroleptic medication. • Individual #217 (DISCUS not obtained because it was deemed N/A) • Individual #125 (DISCUS not obtained because it was deemed N/A) • Individual #278 (DISCUS 3/09/11 score =4) • Individual #60 (DISCUS 11/15/11 score =0) • These individuals did not have a diagnosis of TD. <u>Quality of Completion of Side Effect Rating Scales</u> In regards to the quality of the completion of the assessments, it did not appear that some of the scales were entirely filled in for all categories. For example, Individual #367 had a MOSES completed in September of 2011 with notation "akathisia," however, scoring was not provided for any of the items on the entire MOSES form (i.e., severity or duration). He also was administered a DISCUS on the same date of 9/20/11 with conclusion "no TD" with akathisia present. The psychiatrist had identified this individual as having the diagnosis of "Tardive Dyskinesia, secondary to psychiatric medications." He also had "Extrapyramidal Syndrome," however, none of these findings were summarized in either of the assessment tools. Medication-Induced Movement Disorders should be coded on Axis I, yet for this individual it was only noted on Axis III. The data at SGSSLC regarding diagnostics on Axis I varied depending on what document was reviewed and examples, as such, hindered further progress with this provision. <u>Training and Clinical Application</u> Since the last review, there were two in-service training (6/24/11, 5/31/11) titled the DISCUS/MOSES module, attended by a total of 12 nursing staff for both sessions. The purpose of this provision was for monitoring to result in detection, if present. Once side effects were detected, reporting was to occur and response taken based on the individual's status. To date, upon interviews with the staff at SGSSLC, this exercise had been more of an inservice exercise, rather than resulting in use as a relevant clinical tool. For example, during psychiatry clinic, the team met with Individual #132. This individual exhibited constant facial grimacing and elevation of his eyebrow region bilaterally. On a positive note, the team had successfully discontinued his Lithium, but attempts to reduce his antipsychotic had not been successful. Upon prompting by the monitoring team to discuss the assessment tool, the nurse stated that it was done	

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		without any further explanation. The DISCUS completed 8/2/11 had a score of 0. Perhaps the discontinuation of the psychotropic agent contributed to the eruption of abnormal motor movements or the staff were not competent in administering the scale for this individual with neuroleptic exposure and obvious facial movements. The MOSES had 0's on the entire screen for numerous examinations. This individual also represented a case example of the above-discussed use of PRN of medication, the neuroleptic Haldol, "per his request," when this individual did not have the capacity to consent for treatment. Haldol can contribute to extrapyramidal side effects and tardive dyskinesia (though an 11/1/11 QDDP entry noted that he had not requested his PRN in over two months and "appears to have requested it only once this year." In summary, screening assessments were supposed to be performed, not only according to schedule, but also when there was a change in status or medication regimen that contributed to side effects. Record review supported that during the onsite visit, Individual #132 was assigned a persistent tardive dyskinesia diagnosis 12/6/11 by the treating psychiatrist due to clinical presentation and elevated DISCUS score. <u>Psychiatry Review and Clinical Application</u> Nine individuals were noted to have the diagnosis of tardive dyskinesia (TD). As noted above, this list updated, would reflect 10 individuals because the psychiatrist discovered that Individual #132 had TD during this monitoring visit. The psychiatrists were receptive to feedback from the monitoring team to utilize the information from the screen in combination with the clinical examination to identify and address potential side effects of psychotropic medication. The report of only nine individuals having a diagnosis of TD resulted in the monitoring team's concern about inadequate training and lack of appropriate interpretation of the results of the assessment tool. At the time of the previous review, there were seven individuals diagnosed with TD. Therefore, the number reported at the time of this visit did not appear to be an accurate reflection of the number of individuals experiencing TD. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or the absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. When an individual experienced an adverse drug reaction, reporting of the finding, such as by filling out an ADR, was to occur. ADRs are reviewed in section N.	

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		Monitoring Team's Compliance Rating Given the need for the demonstration of the consistent identification of individuals (i.e., obtaining and applying pertinent history discovered about exposure to medications that cause TD) experiencing side effects and the requirement for the appropriate utilization of this information in clinical decision-making, this item was rated as being in noncompliance.	
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.	Policy and Procedure for Psychiatric Services The psychiatry team presented the SGSSLC policy and procedure dated 5/19/11 to the monitoring team, yet upon further review, a more current SGSSLC facility-specific policy and procedure dated 8/25/11 was found (updated before the release of the statewide policy). Additionally, there was a statewide policy and procedure for psychiatry services dated 8/30/11. It was progress that the facility developed pertinent policy and procedures, however, staff knowledge and implementation was not apparent. Upon inquiry about the details of the statewide and facility policy for psychiatric services, the psychiatry team was not able to explain the clinical relevance and applicability of the content of either policy or what differences existed between the documents. There was improvement via the development of a new process for the documentation of the quarterly psychiatry review, but this was not part of the psychiatry policy and procedure (see J2 above). Treatment Plan for the Psychotropic Medication Per record reviews for 16 individuals, there were no specific treatment plans for psychotropic medication that contained the components required by this provision item. If done correctly, however, the psychiatrist's initial and follow-up evaluations can address the components of a psychiatric treatment plan in the assessment and recommendation sections. A review of documentation did not note consistent inclusion of the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral/pharmacological treatment hypothesis). Other required elements (the expected timeline for the therapeutic effects of the medication to occur, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur) were also not outlined in the records. The monitoring team attended several clinics during the week of the onsite visit. The psychiatry clinics were conducted in the home of the individual at SGSSLC, and provided an adequate work area for the PST to review records, discuss data, write progress notes, and allow the meeting and interview with the individual to occur in a comfortable setting.	Noncompliance

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		Individuals were seen in psychiatry clinic quarterly, or more frequently, as needed. During the monitoring review, three psychiatry clinics were observed. In all instances, the individual was present for the clinic. All treatment team disciplines were represented during each clinical encounter. The team did not rush clinic, often spending more than 30 minutes discussing the individual's treatment, and meeting with the individual. Improvements were noted regarding exchange of pertinent information during some of the psychiatric clinics, however, the data predominantly focused on behavioral presentation (i.e., agitation, self-injurious behavior, or aggression towards others). This information, although relevant, was insufficient if the goal was to implement an evidence-based approach in evaluating medication efficacy associated with a psychiatric disorder. Both of the psychiatrists displayed competency in verbalizing the rationale for the prescription of medication with the monitoring team during the onsite visit, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information, however, must be spelled out in the psychiatric documentation. <u>Use of PRN Psychotropics</u> Individual #39, a minor, was prescribed Thorazine "at her request." This young individual with a developmental disability was assessed as being "unfit to proceed" with her legal charges, yet was given the opportunity to request a sedating antipsychotic medication when she thought the medication was needed. The consent process for this juvenile dated 10/7/11 did not reflect diagnosis consistent with the psychiatrist report or with the diagnosis in the BSP. For example, Individual #39 had a diagnosis of pervasive developmental disorder, NOS, however the consent regarding the Thorazine was for psychosis (i.e., visual and auditory hallucinations). The BSP dated 12/31/10 noted a diagnosis of PDD, NOS with "auditory hallucinations telling her to harm herself and others. Psychotic-trance like behavior, disorganization, poor grooming, aggression, self-mutilation and cruelty to animals." Individual #81 had a developmental disability, was found to "lack responsibility for conduct under Chapter 55," and had a history of using Xanax, Ecstasy, Cocaine, Marijuana, and Nicotine, yet was given the duty to request an agent with addictive qualities (i.e., Ativan) when she thought the medication was needed. The consent dated 6/20/11 noted the individual did not have the capacity to consent. Individual #81 was prescribed a benzodiazepine to "treat anxiety...and to induce sleep," however, her diagnosis was chronic undifferentiated schizophrenia. In the quarterly psychiatric review for Individual #81, the psychiatrist noted that it was	

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		unlikely that the psychiatrist (in the community upon discharge) would continue the two mg Ativan on a PRN basis. There was no guidance from the psychiatrist about the utilization of other treatment options (e.g., non-pharmacological skills) or the potential for further substance abuse and necessary substance education. There was minimal comment about the review of psychotic symptomatology. This type of practice pattern of allowing an individual with these types of characteristics being the delegated decision maker of when to receive a psychoactive medication that can have numerous side effects, did not meet generally accepted professional standards of care and should be evaluated. Note, however, that this was the intent of the lead psychiatrist. Further, please note that the monitoring team understands and appreciates the psychiatrists' attempts to provide psychiatric service in a manner that allows individuals to have additional control over their own treatment. This indeed may have beneficial effects. Even so, it must be done thoughtfully, and these important considerations regarding policy and procedure, consent, logistics of implementation, staff training, and monitoring must be addressed. Further, the DADS state-wide policy for psychiatry services required that ICFMR guidelines were to be implemented for the SSLCs. These included that the use of a PRN (as needed) anti-psychotic drug more than five times, as standing, or as needed, programs to control inappropriate behavior were not permitted under the ICFMR regulations. A drug may be used in an emergency situation, but the emergency drug usage cannot continue until the usage has been approved by the interdisciplinary team and included in the active treatment program (section J3). This provision item also specifically requires that the PST, including the psychiatrist, was to establish the expected timeline for the therapeutic effects of the medication to occur. The team must establish the diagnosis and indications/target symptoms of the medication selected. The monitoring team encouraged the psychiatry team to access the child and adolescent psychiatrist for the assessment and treatment of the youth at SGSSLC (e.g., to review cases of young individuals and to provide guidance regarding the appropriate informed consent process for children and adolescents). Monitoring Team's Compliance Rating A review of a sample of 16 records revealed varying quality in documentation for the psychiatric reviews, with most of the deficiencies noted in the identification of a clinically justifiable diagnosis to ensure that the treatment plan for the medication was consistent with generally accepted professional standards of care. Therefore, the facility remained in noncompliance for this item.	

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J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure Per DADS policy and procedure "Psychiatry Services" dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." The facility-specific policy "Psychiatric Services" dated 8/25/11, did not outline the psychiatrist's role in obtaining consent for psychotropic medications. Per this policy, "San Angelo State Supported Living Center must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications (or other restrictive procedures)." Per the monitoring team's review of other facility-specific language regarding this provision, the psychiatrist must obtain informed consent with steps delineated that must be followed. SGSSLC would benefit from review of the formalization of the informed consent process begun at other SSLCs. At SGSSLC, the psychology department summarized details of restrictive procedures inclusive of psychotropic medications, not the medical department, in the BSP. The monitoring team informed the psychiatry staff that the prescribing practitioner for the medication regimen was the party responsible for establishing the content of the consent process as it relates to the prescription of the psychopharmacological agents. The facility should handle this medical consent consistent with other medical policy and procedures for obtaining consent. A 7/11/11 entry in the POI stated there was a meeting held at SGSSLC that included several Human Rights Officers, QDDP coordinators, and representatives from state office regarding informed consent. The meeting took place from 7/11/11-7/14/11 with the purpose of developing questions that could be used by the PST to assess the individuals' ability to give informed consent in the areas of financial, medical community placement, release of information, release of media and photo, and restrictive practices and programming. A list of questions were composed for each of these an areas in an effort to provide the PST guidance in establishing what level of informed consent each individual can give (that does not have a guardian or parent/conservator). This was good to see. Based on some of the discussions during the week of the onsite review, the process for informed consent was in the initial transition from the psychology department to the medical department, however, this was not clearly documented as noted in the risk-benefit analysis examples presented in J10.	Noncompliance

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		The actual consent must include all of the necessary components of an informed consent procedure for medication. For example, alternatives and associated risks (e.g., therapies/programs available if the individual refuses treatment with medication and that have been considered, tried, and/or rejected), and risk of no treatment need to be included. An adequate risk versus benefit analysis must be documented. There should also be an area where the individual and/or LAR can print their names. This would allow identification of the individual and/or the relationship of the designee for the individual. The consent documents did not include the name of the "person giving explanation." Further, staff must review the estimated duration of the validity of consent for the medication, consistent with state consent guidelines, and whether this should be less for specific measures (e.g., pretreatment sedation medication). A consent form, once completed, was then presented to the Human Rights committee for review before a non-emergency medication was given. <u>Monitoring Team's Compliance Rating</u> This provision remained in noncompliance due to the inadequate informed consent practice at SGSSLC.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	<u>Policy and Procedure</u> Per DADS policy, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when the medications are prescribed to treat both seizures and a mental health disorder." There was also a facility-specific policy and procedure "Communication with Neurologist" dated 4/7/11 with the purpose to ensure appropriate communication between the physicians and neurologist. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 52 individuals. At the time of the previous review, there were 74 individuals listed that required neuropsychiatric intervention to coordinate the use of medications prescribed to treat both seizures and a mental health disorder. There was no reason provided for such a large number (22) of individuals to no longer being listed as requiring services in regards to this provision item. To date, there has been no reference that a neuropsychiatric clinic was ever scheduled. Neuropsychiatric consultation requires the participation of a neurologist and a psychiatrist. The treating psychiatrists did not meet with the treating neurologist	Noncompliance

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		because individuals requiring neurological consultation were evaluated in the community setting, however, the dates of Dr. Chris Vanderzant's neurology clinics were provided; these occurred a couple of times per month. The medical director stated that the community neurologist knew many of the individuals because he had provided neurology care for them for many years. The individuals were not under the care of an epileptologist because the medical director stated the closest expert resided in San Antonio. The spreadsheet provided listed the AED indication as "Seizures or Seizure Disorder" for 100%, but did not note an indication for a mental health disorder for those participating in psychiatry clinic. Consider that if someone was prescribed three anti-epileptic medications for a seizure disorder and also had a diagnosis of bipolar disorder, then the psychiatrist and neurologist would have to determine what regimen would be best suited to target the medical and psychiatric condition. Then appropriate consent for the medications would be obtained and data collected in regards to polypharmacy. Due to the indication for the AEDs not identifying even one instance for Axis I, the data for psychotropic polypharmacy were likely underreported. • The change in medication whether AED from the neurologist or adjustment of psychotropic from the psychiatrist should occur with the plan of one medication change at a time and monitoring of seizures, side effects, drug-drug interactions, and mental status changes. • When one medication is changed, it can actually affect the level of the other medication (i.e., increase or decrease). These type of drug interactions require thorough review particularly for individuals with intractable epilepsy and how this may impact the seizure disorder and mental status presentation. <u>Monitoring Team's Compliance Rating</u> The facility remained in noncompliance with this provision item due to lack of identification of target symptoms for AED regimen that must occur between the neurologist and the psychiatrist.	

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Recommendations:

1. All lists and data submitted to the monitoring team must include a date on the document. Numerous documents received by the monitoring team were not dated and, therefore, it was difficult for the monitoring team to interpret percentages of completion of tasks within the time frame since the last monitoring visit (e.g., J3, J11).

2. Encourage every psychiatric practitioner and all staff assigned to the psychiatry clinic (i.e., psychiatry assistant, nurses, child and adolescent psychiatrist) to update his or her curriculum vitae to include board status (i.e., board eligible or board certified), list of ACGME programs

completed and specific dates of attendance, date of board recertification, date of current medical license, and present job experience at SGSSLC (start date), experience (including timeframe and setting) in working with individuals with developmental disabilities, and identified expertise in all specialties such as forensic psychiatry, and child and adolescent psychiatry. The psychiatrist should also note if he or she has ever been deemed an expert for court testimony in the State of Texas, specifically citing the District, reason, and date of such testimony (J1, J5).

3. The facility should utilize a database to track essential elements of the delivery of services by the psychiatry department, including but not limited to, information confirming current diagnostics, indications of treatment regimen, and tracking of consultation dates in order to ensure individuals were evaluated in a clinically justifiable manner (J2).

4. Revision of the psychiatry policy and procedure to reflect process that occurred within the psychiatric clinic at SGSSLC, in order to instruct the PST about expectations of material to be presented to the psychiatry team per the new quarterly format (J2).

5. Improve data collection regarding the use of emergency psychotropic medications. The use of emergency psychotropic medication is one additional set of data that should become part of the facility's QA program. Include PRN medication in the count of psychotropic medication, with the following information: the name of the medication, dosage, duration of use, indication, date consent was obtained, and by whom (J3).

6. It will be important for collaboration to occur between psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. In this process, the PST will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of emergency medications. It was also imperative that this information was documented in the individual's record in a timely manner (J3).

7. Individualize the desensitization plans for dental and medical clinic. Implement cross-discipline consultation regarding pretreatment sedation options. The clinical pharmacist can provide the potential interactions of pretreatment sedation agents with concurrently prescribed medication to the PST (J4).

8. Develop work-load indicators to determine optimal utilization of present staffing, taking into account not only clinical responsibility, but also documentation of clinical care and required meeting time (e.g., physician's meetings, staffing, behavioral management consultation, emergency PSP, discussions with nurses assigned to psychiatry, call responsibility) (J5).

9. The lead psychiatrist and psychiatry assistant should establish a schedule and procedure for Appendix B evaluations to be completed. The psychiatry staff should utilize a consistent numeral system with similar categories in order to address all of the components as outlined in Appendix B (J6).

10. Administer the Reiss screen for each individual upon admission, and as outlined in provision J7.

11. Ensure that the clinical indicators/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate (J2, J8, J13).
    a. If DSM-IV-TR diagnosis was met, utilize medication that has validated efficacy as supported by evidence-based practice, and that was the appropriate course of intervention in concert with behavioral intervention.
    b. Review the target symptoms and data points currently being collected for individuals prescribed psychotropic medication. Make adjustments to the data collection process (i.e., specific data points) that will assist psychiatry in making informed decisions regarding psychotropic medications. These data must be presented in a manner that is useful to the physician, that is, in graph form, with

medication adjustments, identified antecedents, and specific stressors identified.

c. For each individual, this information must be reflected in the case formulation and psychopharmacological treatment plan with illustration of collaboration with the PST.

12. Integrate the prescribing psychiatrist into the overall treatment program at the facility as follows (J3, J8, J9, J13):
    a. In discussions regarding treatment planning and behavioral support planning;
    b. Utilize the psychiatric treatment plan for psychotropic medications written per the psychiatrist in the overall team treatment plan;
    c. Ensure the individual's psychiatric diagnosis is consistent across disciplines;
    d. Involve psychiatrists in decisions to utilize emergency psychotropic medications;
    e. Psychiatry should be consulted regarding non- pharmacological interventions.

13. Formalization of the PSP process to include review of the risk/benefit ratios for the prescription of psychotropic medications and to be authored by psychiatry. Individualize the risk versus benefit for each psychotropic medication prescribed. The risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the risk/benefit analysis (J10).

14. Summarize data on utilization of psychotropic medication. Ensure dates are recorded on all documents and legible. The psychiatrist should utilize the findings obtained via the polypharmacy review committee as it relates specifically to the medication regimen prescribed for each individual and for the review of the prescribing psychiatrist's practice pattern regarding polypharmacy. Continue efforts to improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented (J11).

15. Code Medication-Induced Movement Disorders on Axis I. Provide a numbered alphabetized list of individuals that received a DISCUS and MOSES with the dates of completion for the past two evaluations inclusive of the scores of each screen (J12).

16. Any change in diagnostics should summarize the symptoms and criteria met according to DSM-IV-TR to justify the diagnosis. The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication (J2, J8, J13).

17. In an effort to address the deficit regarding informed consent practices, it is recommended that the facility consult with the state office that, in turn, may want to consider a statewide policy and procedure outlining how to obtain appropriate informed consent that comply with Texas state law and generally accepted medical practice (J14).

18. The facility must consider options for implementing neuropsychiatric clinic consultation. This may include exploring consultation with medical schools and considering telemedicine consultation with providers currently contracted in other DADS facilities. It would be helpful for the facility to learn how other centers are addressing necessary interaction between psychiatry and neurology to implement clinical coordination of care (e.g., monthly neuropsychiatric clinic) (J15).

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Positive Behavior Support Plans (PBSPs) for: • Individual #142 (9/7/11), Individual #400 (8/26/11), Individual #290 (8/12/11), Individual #10 (10/26/11) Individual #123 (10/5/11), Individual #22 (7/22/11), Individual #94 (6/10/11), Individual #292 (9/9/11), Individual #162 (9/9/11), Individual #399 (9/9/11), Individual #116 (10/26/11), Individual #215 (7/15/11) o Six month progress reviews of PBSPs for: • Individual #123, Individual #22, Individual #92, Individual #162, Individual #200 o Functional Assessment for: • Individual #10 (10/5/11), Individual #200 (11/16/11) o Annual Psychological updates for: • Individual #352 (11/3/11), Individual #68, (11/12/11), Individual #305, (8/5/11), Individual #300, (6/3/11), Individual #163 (9/26/11), Individual #55 (8/15/11); Individual #252 (9/16/11), Individual #353 (10/24/11), Individual #249 (10/24/11), Individual #22 (11/3/11) o Full Psychological Assessments for: • Individual #105 (6/22/11), Individual #7 (8/24/11), Individual #150 (8/23/11), Individual #312 (9/2/11) o Section K Presentation Book, undated o San Angelo Plan of Improvement, dated 11/22/11 o Blank Scan Card, no date o Scan Card instructions to staff, dated 10/21/11 o Policy and Procedures for Session Psychology, dated 10/6/11 o Session Psychology Services Referral Form- Fall Semester o Session Psychology progress note o Avoidance Safety Plan for: • Individual #190 o Avoidance Safety Plan for: • Individual #349 o Sessions Treatment Plan and Progress Summary for: • Individual #117, Individual #114, Individual #193, Individual #234, Individual #293, Individual #277, Individual #48, Individual #382, Individual #352, Individual #55 o Progress note training (for Psychological Services other than PBSPs), no date o Policy and Procedures for Referrals to Therapeutic and Psycho-Educational Services, dated 10/6/11 o Treatment Integrity Committee Meeting Minutes, dated 7/15/11, 7/19/11

	o Policy and Procedure for Competency, Reliability, and Interobserver Agreement Assessment, dated 10/7/11 o Treatment Integrity data sheet for: • Individual #3 o Spreadsheet including date of Individual Annual Psychological Assessments, undated o List of Individuals with Functional Assessments completed in the last six months o List of Individuals with a PBSP and dates of last plan revision, undated o List of Individuals receiving therapy/psycho-educational therapies o Policy/Procedure for Psychological and Behavioral Services, dated 4/28/11 o Policy/Procedure for Positive Behavior Support Committee, dated 12/16/10 o Policy/Procedure for Psychology Internal Peer Review Committee (PIPRC), dated 1/27/11 o Policy/Procedure for Psychology External Peer Review Committee (PEPRC), dated 8/25/11 o Blank token exchange card and token data sheet for Individual #265 o Group therapy session schedules for Monday/Wednesday, Tuesday/Thursday, and Friday o Child Avoidance Safety Plan o Various documents regarding Individual #42 <u>Interviews and Meetings Held</u>: o Robb Weiss, Psy.D., Director of Psychology o John Church, Associate Psychologist o Dana Robertson, Associate Psychologist o Erick Ybarra, Associate Psychologist o Felicia Lindsey, Psychology Assistant o Patricia Trout, Unit Director; Cedric Woodruff, Unit Director; Vicki Hinojos, Unit Director o Mary Jane Bajaj, M.A., LPC, LSOTP <u>Observations Conducted</u>: o Psychiatry Clinic Rounds: • Staff attending: Dr. Mercer, Psychiatrist; Erick Ybarra, Associate Psychologist; Mike Fletcher, QDDP; John Church, Associate Psychologist; Roger Abalos, Home Manager; Sharon Fagan, RN; Carlos Guerrero, PA-Student • Individuals Presented: Individual #124, Individual #142 o Psychiatry Clinic Rounds: • Staff attending: Dr. William Bazzell, Psychiatrist; Roy Guevara, Psychiatric RN; Kevin Huyler, QDDP; Polly Castro, Home Manager; Cleo Ortiz Associate Psychologist; Anna Pittman, RN • Individual presented: Individual #196 o Psychology Internal Peer Review Committee • Staff attending: Robb Weiss, Director of Psychology; Spencer Washington, Associate Psychologist; Jane Bajaj, SOTP; Patricia Campbell, Associate Psychology; Barbara Cunningham, Associate Psychologist; Norma McDonald, Associate Psychology; Sim Nyakunika, Associate Psychologist; Cleo Ortiz, Associate Psychology; Amanda Rodriguez,

	Associate Psychology; Irma Rangel, Psychology Secretary; Robbie Potter, Psychology Assistant; John Church, Associate Psychologist; Lynn Zaruba, Associate Psychologist; Jennifer Quisenberry, Psychology Assistant; Erick Ybarra, Associate Psychologist; Neal Perlman, Associate Psychologist; Elizabeth Love, Psychology Assistant; Ermelinda Samaripa, Psychology Assistant, Thomas Talbot, Associate Psychology • Individual Presented: Individual #200 o Behavior Support Plan Committee (BSPC) Meeting • Staff Attending: Robb Weiss, Director of Psychology; Jim Mercer, Psychiatrist; Angela Kissko, QA Director; John Church, Associate Psychologist; Lynn Zaruba, Associate Psychologist; Barbara Cunningham, Associate Psychologist • Individual Presented: Individual #42 o Psychology Department Meeting • Staff Attending: Robb Weiss, Director of Psychology; Spencer Washington, Associate Psychologist; Jane Bajaj, SOTP; Patricia Campbell, Associate Psychology; Barbara Cunningham, Associate Psychologist; Norma McDonald, Associate Psychology; Sim Nyakunika, Associate Psychologist; Cleo Ortiz, Associate Psychology; Amanda Rodriguez, Associate Psychology; Irma Rangel, Psychology Secretary; Robbie Potter, Psychology Assistant; John Church, Associate Psychologist; Lynn Zaruba, Associate Psychologist; Erick Ybarra, Associate Psychologist; Elizabeth Love, Psychology Assistant; Ermelinda Samaripa, Psychology Assistant, Thomas Talbot, Associate Psychologist, Judy Berma, Associate Psychologist; Shirley Bilbrey, Therapy Tech; Jacquelyn Bishop, Tech II; Patrick Durgin, Psych Tech; Samantha Eubanks, Tech II; Rebecca Flygare, Tech II; Coleen Glass, Therapy Tech; Michele Gloria, Psychology Assistant; Erika Gonzalez, Psychology Tech; Lacey Jones, Tech II; Felicia Lindsey, Psychology Assistant; Brandy McAlister, Psychology Assistant; Shawnda Morgan, Therapy Tech; Maggie Smith, Associate Psychologist; o Group therapy sessions: LSOTP, DBT o Observations occurred in various day programs and residences at SGSSLC. 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), and • Implementation of behavior support plans
	Facility Self-Assessment: The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. In the comments section of each item of the provision, the director of psychology identified what tasks had been completed and the status of each provision item.

	The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. SGSSLC's POI indicated compliance for items K2, and noncompliance for all other items of this provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment except for K8, which was also rated as in substantial compliance. The POI established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur in the way psychology services are provided, and because it will likely take some time for SGSSLC to make these changes, the monitoring team suggests that the facility establish, and focus their activities, on short-term goals. The specific provision items that the monitoring team suggested that the facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Although only two of the items in this provision were found to be in substantial compliance with the Settlement Agreement, there has been continued progress. The improvements since the last onsite review included: • Four psychologists completed coursework for board certified behavior analyst (BCBA) certification. All of remaining psychologists that write Positive Behavior Support Plans (PBSPs) either had their BCBA (one individual) or were enrolled in BCBA coursework (K1) • Continued improvements in the data collection system (K4) • The beginning of the collection of replacement behaviors (K4) • The establishment of the collection of inter-observer agreement (IOA) data (K4) • The establishment of treatment integrity data (K4, K11) • Improvements in the quality of the functional assessments (K5) • Substantial improvements in ensuring that therapies and psycho-educational sessions were goal directed, with measurable goals and progress towards those goals (K8) • Improvements in the quality of PBSPs (K9) The areas that the monitoring team suggest that SGSSLC focus on during the next six months are: • Ensure that internal peer review occurs at least weekly, and external peer review monthly (K3) • Establish data collection reliability, determine reliability goals, and pilot a method to ensure that they are achieved in at least one home (K4) • Establish IOA goals, and pilot a method to ensure that they are collected and recorded, and goals are maintained in at least one home (K4) • Ensure that improved graphs are routinely used to make data-based treatment decisions (K4, K10) • Establish treatment integrity goals, and pilot a method to ensure that they are collected and recorded, and goals are maintained in at least one home (K4, K11) • Ensure that full psychological assessments contain all the necessary components (K5)

	• Increase the number of functional assessments conducted (K5) • Ensure that all direct functional assessments include observations of target behaviors (K5) • Ensure that annual psychological assessments contain all the necessary components (K7)

#	Provision	Assessment of Status	Compliance
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.	Despite continued progress in his provision item, it was rated as being in noncompliance because not all psychologists at SGSSLC were certified as applied behavior analysts, and due to inconsistency in the quality of the positive behavior support plans (see K9). At the time of the onsite review, one psychologist was a board certified behavior analyst (BCBA). Four psychologists had completed the required coursework for the BCBA and were waiting to sit for the national exam. The remaining psychologists that wrote Positive Behavior Support Plans (PBSPs) were enrolled in course work toward the BCBA. SGSSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. The facility had developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility continued to be in substantial compliance with this item. The director of psychology had a Psy.D. and was licensed in several states, including Texas. He was a member of the Psychological Association of Greater West Texas, and had over 15 years of experience working with individuals with intellectual disabilities. Additionally, Dr. Weiss was recently approved to sit for the BCBA exam based on his training and experience. Finally, under Dr. Weiss' leadership, several initiatives had begun toward the attainment of substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Since the last review, the facility had revised internal peer review meetings and began to conduct external peer review meetings. Review of minutes, however, indicated that they did not occur at the intervals required in this item of the Settlement Agreement. Therefore, this item was rated as being in noncompliance. SGSSLC continued to conduct Behavior Support Plan Committee (BSPC) meetings weekly. As discussed in the last report, these meetings primarily reviewed cases that required annual approval of PBSPs or safety plans. The facility has recently modified the	Noncompliance

#	Provision	Assessment of Status	Compliance
		Psychology Internal Peer Review Committee (PIPRC) meetings to address the opportunity to present cases that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #200's functional assessment and PBSP, and included participation by the majority of the psychology department. The peer review meeting included active participation among the psychologists, and resulted in the identification of several new interventions to address this individual's target behaviors. Additionally, the facility recently expanded peer review by conducting Psychology External Peer Review Committee (PEPRC) meetings. These meetings had only recently been initiated. These should be designed to consist of peer review meetings that, at minimum, include other Texas DADS, BCBAs, and supervisors (perhaps by teleconference) that were not directly involved in the development of the facilities PBSPs. Operating procedures for the PIPRC were provided to the monitoring team. Documentation that internal peer review occurs at least weekly, and that external peer review occurs at least monthly will need to be established prior to achieving substantial compliance with this provision item.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	There were several improvements in this provision item since the last onsite review. In order to achieve substantial compliance, however, the facility needs to implement data collection reliability and the planned interobserver agreement (IOA), collect and graph replacement behaviors, and ensure that graphs are routinely used to make data based treatment decisions. The facility had recently implemented a new simplified data collection system. The new system included the use of Scan Cards. Scan Cards were preprinted individual cards, containing categories of target behaviors that direct care professionals (DCPs) used to record target behaviors. The cards could then be scanned and used to produce graphs of the data. The Scan Cards reviewed did not, however, contain replacement behaviors. It is recommended that replacement behaviors be added to the Scan Cards. The ease of implementation (e.g., many DCPs were observed carrying the cards with them) and the simple process from data collection to graphing were clear advantages of this system of data collection. The data system required DCPs to record a predetermined code in each recording interval (15 minutes) if the behavior did not occur. This procedure ensured that the absence of target behaviors in any given interval did not occur because staff forgot to record the data. This requirement also allowed for the review of data cards to determine if DCPs were recording data at the intervals specified (i.e., data collection reliability).	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team did its own data collection reliability by sampling individual Scan Cards across several homes, and noting if data were recorded up to the previous recording interval for target behaviors. The results are presented below: • The target behaviors sampled for seven of 10 Scan Cards reviewed (70%) were completed up to the previous recording interval. Two of the three homes reviewed that had cards that were not completed up to the previous recording interval, had at least one other card that was current (i.e., 509A and 510A). These results were encouraging, but suggested that there was room for improvement. Consistently high levels of data collection reliability increase confidence in reported data because it is an indication that staff are recording data immediately after it occurred, rather than attempting to recall it hours later. It is recommended that the facility initiate its own data collection reliability for all target behaviors (and replacement behaviors when those data are added to the Scan Cards) collected in each home and day/vocational site. Finally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals. Another area where the facility had improved since the last review was the beginning of the development of inter-observer agreement (IOA) measures. As discussed in the last report, the addition of data collection reliability described above (which assesses whether data are recorded), along with IOA data (which assesses if multiple people agree that a target or replacement behavior occurred) represent the most direct methods for assessing and improving the integrity of collected data. Now, the facility needs to establish specific IOA and data collection goals, and arrange to provide staff with performance feedback to achieve and maintain those goals. Because the systems necessary to track and increase data collection reliability, IOA, and treatment integrity (see K11) require the cooperation of departments other than psychology (e.g., DCPs, unit directors) and require the development of new tools (e.g., tracking systems), it is suggested that the facility pilot the tracking of these behavioral systems in one or two homes. This will allow the facility to work out the logistical challenges, and better assess the additional resources that will be necessary to implement it across the all homes and day/vocational sites. As indicated in the last report, SGSSLC had improved the graphing of target behaviors. For example, Individual #186's target behaviors were graphed in weekly intervals, and Individual #200's graphs included phase lines indicating potentially important environment changes (e.g., moves to different residences, medication changes) that quickly allowed the reader to evaluate the effectives of these changes on Individual #200's behavior. These potentially useful graphs, however, were not consistently present in the psychiatric meetings observed by the monitoring team (also see section J).	

#	Provision	Assessment of Status	Compliance
		For example, in Individual #142's and Individual #196's psychiatric meetings, no graphed target or replacement data were presented. It is recommended that graphed data (including both target and replacement behaviors) be consistently presented at all treatment review meetings so that data based decisions can be made. The monitoring team had requested six months of progress notes for 10 individuals with PBSPs. Only five of those individuals had recent progress notes. Overall, there were not monthly progress notes for all individuals with PBSPs. Psychology staff were aware of the need to have these done. It is recommended that all individuals with PBSPs have current progress notes. In reviewing severe behavior problems (i.e., physical aggression and self-injurious behavior) for those five individuals, two or 40% (Individual #123 and individual #22) indicated clear decreases (or maintained a low level) in at least one severe behavior. This represented an improvement from the results from the last onsite review when 14% of the plans reviewed indicated improvements (or maintenance of low levels) in dangerous behaviors. As reported in the last review, there was evidence that some PBSPs were modified, before the annual review, due to lack of progress (e.g., Individual #94). Clearly, the lack of treatment progress is not likely to be solely the result of an ineffective PBSP, however, the monitoring team does expect that the progress note or PBSP would indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred if an individual was not making expected progress. The monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological and functional assessments for each individual, and the lack of comprehensiveness of some of those assessments. <u>Psychological Assessments</u> The director of psychology reported that not all individuals at the facility had an initial (i.e., full) psychological assessment. Four of the seven initial psychological assessments completed in the last six months (57%) were reviewed. As reported in the last (May 2011) review, none of the initial psychological assessments reviewed were found to be complete. • Three of the initial psychological assessments (i.e., Individual #105, Individual #312, and Individual #150) did not include medical information. • One initial psychological assessment did not include an intellectual assessment (Individual #7).	Noncompliance

#	Provision	Assessment of Status	Compliance
		All individuals at SGSSLC should have an initial (full) psychological assessment. Additionally, these initial psychological assessments should include an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. <u>Functional Assessments</u> As noted in the last report, the director of psychology had indicated that not all individuals with a PBSP had a functional assessment. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors. A list of all functional assessments completed in the last 12 months indicated that two were completed since the last review. Both of those functional assessments (100%) were reviewed to assess compliance with this provision item. As discussed in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. All functional assessments should include direct and indirect assessment procedures. A direct assessment consists of direct and repeated observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect assessments help to understand why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. Both of the functional assessments reviewed included appropriate indirect functional assessments. One (i.e., Individual #200) of the direct functional assessments reviewed (50%) was rated as complete. Although the sample was very small (because only two functional assessments were completed since the last review), this represented a substantial increase in the percentage of direct functional assessments rated as complete compared to the last review (i.e., 10%). The complete direct assessment is described below. • Individual #200's functional assessment included observations of target behaviors and descriptions of events hypothesized to function as an antecedent to physical aggression. The direct functional assessment also included an analysis of time of the day, setting, and target (peer or staff) of physical aggression to better understand the behavior. This direct assessment revealed that Individual #200's physical aggression was most likely to occur toward peers, on first shift, and in the residence. The other functional assessment reviewed did not clearly include direct observations. Individual #10's direct functional assessments consisted of direct observations, but since it did not include the observation of any target behaviors, it did not provide any	

#	Provision	Assessment of Status	Compliance
		additional information about relevant antecedent or consequent events affecting the target behavior. Direct and repeated observations of target behaviors in the natural environment are an essential component of an effective functional assessment. All functional assessments should include direct functional assessments that include target behaviors and provide additional information about the antecedents and consequences affecting the target behavior. The accuracy and usefulness of these direct observations is greatly enhanced by recording and presenting the relevant antecedents, behaviors, and consequences as they occur. As discussed in previous reports, one potentially effective way to collect direct functional assessment data is to use ABC (i.e., the systematic collection of antecedent, target, and consequent behavior) data. In order to be useful, however, ABC data need to be collected for a duration long enough to observe several examples of the of the target behavior, and sufficiently repeated so that patterns of antecedents and consequences could be identified. Both of the functional assessments reviewed (100%) identified potential antecedents and consequences of undesired behavior that would likely be useful for developing effective PBSPs for reducing undesired behaviors. Examples of potentially useful antecedents included in the functional assessment were: • Individual #10's functional assessment identified being asked to wait for a cigarette, and to take a shower or clean his room, as antecedents to his target behaviors. • Individual #200's functional assessment identified being prompted to get off the phone and to complete daily living activities, as antecedents to his undesired target behaviors. Examples of potentially useful consequences of the target behavior identified included: • Staff discontinuing the prompting of demands following Individual #10's verbal threats (i.e., negative reinforcement). • Individual #200 gaining access to desired objects/activities (e.g., phone use) following attempts at physical aggression and/or property destruction (positive reinforcement). This represented an improvement in the identification of useful antecedents (90%) and consequences (60%) reported in the last review (May 2011). As discussed in the last report, when comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional	

#	Provision	Assessment of Status	Compliance
		assessment needs to integrate these ideas and observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Both of the functional assessments reviewed (100%) included a concise summary statement. This represented another improvement from the last review when only 10% of the functional assessments reviewed were judged to have a clear summary statement. There was no evidence during this review that functional assessments at SGSSLC were reviewed and modified when an individual did not meet treatment expectations. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment (with a maximum of one year between reviews). One (Individual #200) of the two functional assessments reviewed (50%) was evaluated to be comprehensive and clear. This represented an improvement over the last report when none of the functional assessments reviewed were evaluated as acceptable. Both of the functional assessments reviewed, however, contained excellent components that should be modeled for future reports. Those included: • Good comprehensive summary statements • Good description of potential antecedents and consequences affecting target behaviors Although only two functional assessments were completed in the last six months, they represented a substantial improvement over those reviewed in the last review. One of the factors that may have contributed to this improvement was the establishment of the psychology pre-review committee (PPRC), where new functional assessments were reviewed and approved. In any case, the monitoring team was very pleased with the progress SGSSLC was making in the quality of functional assessments. It is recommended that the facility now develop a plan to ensure that all individuals with a PBSP have a current functional assessment.	
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.	None of SGSSLC's initial (full) psychological assessments were complete (K5) and, therefore, this provision item was rated as being in noncompliance. Three of the intellectual assessments contained in the four initial psychological assessments reviewed (75%) were current (i.e., conducted in the last five years). Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance

#	Provision	Assessment of Status	Compliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In addition to the initial or full psychological assessment, an annual psychological update should be completed each year. The purpose of the annual psychological assessment, or update, is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should contain the elements identified in K5 and comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. A list of annual assessments indicated that they were not completed for 22 individuals at SGSSLC. Additionally, the list indicated that 60 annual assessments were more than 12 months old. All individuals at SGSSLC should have annual assessments. The monitoring team reviewed 10 of the annual psychological assessments to assess their comprehensiveness. • All 10 psychological updates (100%) contained a review of behavioral/psychiatric status • Nine of 10 psychological updates (90%) contained a standardized assessment of intellectual and adaptive ability • Five of 10 updates (50%) contained a review of personal history • None (0%) contained a review of medical status In order to achieve compliance with this item of the Settlement Agreement, all psychological updates will need to contain all of the components described in K5. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of two admissions to the facility in the last six months (i.e., Individual #305 and Individual #300) indicated that this component of this provision item was in substantial compliance.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Psychological services, other than PBSPs were provided at SGSSLC. This was an area in which the facility had made substantial improvements in the last two reviews. These improvements have resulted in substantial compliance with this provision item. At the time of the onsite review, 26 therapies and psycho-educational classes (more than 100 group sessions per week on a variety of topics, including LSOTP and DBT) and individual therapy were offered, and 115 individuals were actively receiving therapy/classes. Ten individual treatment plans and progress summaries were reviewed to assess compliance. Additionally, the monitoring team observed three group therapies/classes.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		All therapies/classes reviewed were found to be goal directed, with measurable objectives, specific treatment expectations, and appeared to be derived from evidence-based practices. There was documented review of progress, and each treatment plan reviewed included a "fail criterion" and a plan for the generalization of acquired skills. The facility developed a referral form that documented the need for services. Observations of group sessions indicated that there was a clear objective for each class, and measureable progress toward that goal was recorded. Staff who provide therapeutic interventions were qualified to do so through specialized training, certification, or supervised practice. Staff who assisted in therapy, or who supervised homework or milieu activities, received training and monitoring from qualified therapists. SGSSLC has achieved substantial compliance with this provision item.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	This item was rated as being in noncompliance because not all PBSPs reviewed contained adequate use of all of the components necessary for an effective plan, and many of the interventions were not clearly based on functional assessment results. A list provided to the monitoring team indicated that 41 PBSPs were written or revised since the last onsite review. Twelve of these (29%) were reviewed to evaluate substantial compliance with this provision item. The facility had recently modified the format of the PBSP. Two of the PBSPs utilized a format different than the other 10. The facility POI indicated that approximately 30% of PBSPs do not have current consent and approvals. All PBSPs should have current approvals and consent. All PBSPs reviewed included descriptions of target behaviors, however, eight (67%) of these were not operational. This represented an improvement in operational definitions from the last review when 92% of PBSPs were rated as having definitions that were not operational. Examples of definitions that were not operational are highlighted below: • Individual #142's PBSP defined obsessive behavior as "… excessive picking of his nails, excessive time spent grooming…" This definition required the reader to infer if Individual #142 was indeed spending excessive time picking his nails or grooming. • Individual #290's PBSP defined physical aggression as "Any action…. with the apparent intention of causing injury…" This definition also required the reader to infer if Individual #290 did indeed have an intention to injure someone as opposed to hitting them. An operational definition should not require DCPs to infer an individual's intentions, or determine if something is excessive. An operational definition should only include observable behavior (e.g., hitting or	Noncompliance

#	Provision	Assessment of Status	Compliance
		kicking others, spending more than five minutes grooming). An example of a well written operational definition was: • Individual #10's target behavior of verbal threatening was defined as an episode lasting up to 15 minutes that involved threatening to leave the home, hurting staff, cursing, and/or yelling at staff. All PBSPs should include operational definitions of target behaviors. All 12 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but three (i.e., Individual #290, Individual #99, and Individual #94) of these (25%) identified antecedents and/or consequences that did not appear to be consistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening an undesired behavior. This represented an improvement from the last review when 67% of the PBSPs reviewed were judged to be inconsistent with the stated function. An example of a consequent intervention not related to the hypothesized function was: • Individual #94's PBSP hypothesized that her undesired target behaviors may have been maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). Her PBSP, however, included removing her from the environment following physical or verbal aggression. If avoiding undesired activities was reinforcing for Individual #94, then this intervention would likely increase the likelihood of verbal and/or physical aggression. Ideally after the aggression occurred, Individual #94 should not be allowed to escape the undesired activity until she appropriately requests it. If the nature of the aggression is such that it is dangerous to maintain her in the activity following aggression, however, then the PBSP should specify her return to the activity when she is calm, and again encourage her to escape or avoid the demand by using desired forms of communication. The PBSP needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future aggressive behavior. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #400's PBSP hypothesized that his self-injurious behavior (SIB) functioned primarily to gain staff attention and desired objects. Antecedent interventions included ensuring that Individual #400 was provided with positive attention when exhibiting appropriate behavior, and by encouraging him to ask for the things he wants. His intervention following SIB included	

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		telling him to stop, blocking SIB to ensure his safety, and specified that staff should minimize attention as much as possible. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior. Replacement behaviors were included in all 12 PBSPs reviewed. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified and providing the reinforcer for alternative behavior is practical. As reported in the last review, the monitoring team found that 10 of 10 (100%) of the replacement behaviors that could be functional were functional. The majority of replacement behaviors reviewed, however, appeared to be behaviors that staff needed to do, rather than skills the individual needed to acquire. For example • Individual #10's replacement behavior was for staff to offer him a choice of tasks to complete before class. In contrast other functional replacement behaviors appeared to require the acquisition of a new skill. For example: • Individual #123's replacement behavior consisted of teaching him to ask for a break. It is recommended that replacement behaviors that require the acquisition of new behaviors include skill acquisition plans (SAPs) for training. Moreover, these plans should be included into the current methodology, data system (when appropriate), and schedule of implementation for other SAPs at SGSSLC. 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 of this report). Finally, although all of PBSPs reviewed included functional replacement behaviors, not all of the PBSPs included the reinforcing of the replacement behaviors in the PBSP. For example Individual #116's replacement behavior consisted of her telling staff that she wants their attention. The antecedent section of her PBSP instructed staff to attend to her for appropriate behavior, but did not specifically instruct them to attend to her if she asked them for attention. It is recommended that when functional replacement behaviors are determined to be practical and possible, that they be included in each PBSP.	

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		Overall, three (Individual #10, Individual #400, and Individual #123) of the 12 PBSPs reviewed (25%) represented an example of a complete plan that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented an improvement over the last review when only 8% of the PBSPs reviewed were judged to be acceptable. The monitoring team was encouraged by the overall progress in the quality of PBSPs at SGSSLC, and looks forward to continued improvements in this provision item.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The monitoring team was encouraged by the plans for the collection of IOA measures at SGSSLC. In order to achieve substantial compliance with this provision item, however, a system to regularly assess and maintain minimum levels of accuracy of PBSP data across the entire facility will need to be implemented (see K4). Target behaviors were consistently graphed monthly at SGSSLC. As discussed in K4, the quality and usefulness of many of these graphs have improved. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path. Replacement behaviors were not, however, consistently graphed. All individuals should have replacement/alternative behavior graphs (See K4).	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	Another area of improvement since the last review was the establishment of the collection of treatment integrity. This provision item was rated as being in noncompliance, however, because at the time of the onsite review, treatment integrity was not consistently collected and recorded across the entire facility. SGSSLC continued to monitor PBSPs to ensure that they were written so that DCPs could understand and implement them. Five (Individual #290, Individual #215, Individual #162, Individual #99, and Individual #292) of the 12 PBSPs reviewed (42%), however, contained six or more target behaviors. That number of target behaviors would decrease the likelihood that DCPs would record or implement the plans with integrity. It is recommended that the facility attempt to reduce the number of target behaviors (many appeared to be part of the same response class, so could be combined). The only way to ensure that PBSPs are implemented with integrity, however, is to regularly collect treatment integrity data. In order to achieve substantial compliance with this provision item, the integrity data	Noncompliance

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		should be tracked and reviewed regularly, and minimal acceptable integrity measures established and maintained. As discussed in the last report, these integrity data need to include direct observations of staff implementing PBSPs. The monitoring team looks forward to reviewing integrity data during the next onsite review.	
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.	The psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. The trainings were reported to be conducted by psychologists and psychology assistants prior to PBSP implementation, and whenever plans changed. Additionally, the facility has planned to add a competency based staff-training component. Although improving, more work in this area is needed to achieve substantial compliance with this item. The monitoring team could not observe any staff training of PBSPs because none were scheduled during the onsite review. The monitoring team will observe and comment on the strengths and weaknesses of the current training procedures during subsequent onsite reviews. There was no system in place to ensure that all staff (including relief staff) had been trained. Additionally, there was no systematic way to identify all of the staff who required remedial training. In order to meet the requirements of this provision item, the facility will need to present documentation that every staff assigned to work with an individual has been trained (including a competency based component) in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter. Additionally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SGSSLC had a census of 245 individuals and employed 10 psychologists responsible for writing PBSPs. Additionally, the facility employed two psychology technicians and four psychology assistants to assist those psychologists. As discussed in K1, the facility had one psychologist with a BCBA. In order to achieve substantial compliance with this provision item, the facility must have at least nine psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. Ensure that internal peer review occurs at least weekly, and external peer review monthly (K2).
3. Add replacement behaviors to all Scan Cards (K4).
4. The facility should initiate data collection reliability for all target and replacement behaviors. Additionally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals (K4).
5. Implement the planned IOA data collection procedures, and establish specific IOA and data collection goals, and arrange to provide staff with performance feedback to achieve and maintain those goals (K4).
6. Ensure that graphs (including both target and replacement behaviors) are routinely used to make data-based treatment decisions (K4, K10).
7. All individuals with PBSPs should have monthly progress notes (K4).
8. All individuals at SGSSLC should have an initial (full) psychological assessment. Additionally, these initial psychological assessments should include an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status (K5).
9. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors (K5).
10. All functional assessments should include direct functional assessments that include the observation of target behaviors and provide additional information about antecedents and consequences affecting the target behavior (K5).
11. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that it be included in a revision of the functional assessment (with a maximum of one year between reviews) (K5).
12. All initial (full) psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).
13. All individuals at SGSSLC should have annual psychological assessments (K7).
14. All annual psychological assessments need to contain all of the components described in K5 (K7).
15. All PBSPs should have necessary approvals and consents (K9).
16. All PSSPS should have operational definitions of target and replacement behaviors (K9).
17. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior (K9).

18. It is recommended that replacement behaviors that require the acquisition of new behaviors include skill acquisition plans (SAPs) for training (K9).

19. When functional replacement behaviors are determined to be practical and possible, they should be included in the PBSP (K9).

20. All individuals should have replacement/alternative behavior graphs (K10).

21. Attempt to keep the number of target behaviors to a minimum (K11).

22. The treatment integrity system should be expanded to all homes, data regularly tracked, and minimal acceptable integrity scores established and maintained (K11).

23. The facility needs to provide documentation that all staff assigned to work with an individual has been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter. This training should include a competency-based component. Additionally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP (K12).

24. It is suggested that the facility pilot the tracking of the recently developed behavioral systems (i.e., data collection reliability, IOA, and treatment integrity) in one or two homes, prior to attempting to implement them across the entire facility (K4, K11).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 2/16/11 o DADS Policy Preventive Health Care Guidelines, 8/30/11 o DADS Policy#006.2: At Risk Individuals, 12/29/10 o DADS Policy#09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044.2: Emergency Response, 9/7/11 o DADS Policy #003: Quality Enhancement, 11/13/09 o SGSSLC Organizational Charts o SGSSLC Policy/Procedure: Medical Care, 6/23/11 o SGSSLC Policy/Procedure: Establishing and Changing Diagnosis, 9/2/11 o SGSSLC Policy/Procedure: Pretreatment Sedation Notification, 2/22/11, rev. 11/16/11 o SGSSLC Policy/Procedure: Consultation Process, 12/8/09, rev. 8/25/11 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o SGSSLC Policy/Procedure: SGSSLC Policy/Procedure: Routine Laboratory Tests and Screenings, 11/18/10 o SGSSLC Lab Matrix, 9/15/11 o SGSSLC Policy and Procedure, Seizure Management Guidelines, 11/2/11 o Quarterly Medical Review Template, 10/20/10 o Listing, Individuals with seizure disorder o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o Report of external medical reviews conducted in June 2011 o Results of internal medical reviews conducted July – October 2011 o Medical caseload data o Presentation Book for Section L o POI for Section L o Daily Provider Meeting Minutes, October – November 2011 o QA/QI Council Meeting: Quality Assurance Report, October 2011 o Quality Improvement Council Notes, 6/27/11, 7/5/11, 7/18/11, 7/25/11, 8/22/11, 8/29/11, 9/19/11, 9/26/11, 10/17/11, 10/19/11, 10/24/11 o Mortality Review Documents

	o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, psychiatric assessments, MOSES/DISCUS forms, quarterly drug regimen reviews, quarterly medical summaries, consultation reports, physician orders, integrated progress notes, annual nursing summaries, health management plans, diabetic records, seizure records, vital sign sheets, bowel records, MARs, annual nutritional assessments, dental records, annual PSPs, and PSP addendums for the following individuals: • Individual #179, Individual #295, Individual #278, Individual #293, Individual #225, Individual #124, Individual #352, Individual #309, Individual #330, Individual #206, Individual #203, Individual #274 Individual #109, Individual #69 o Components of the active integrated record- annual medical summary, preventive care flowsheets, active problem list, consults, quarterly medical summary, labs, immunization records, most recent QDRR and MAR, and PSP for the following individuals: • Individual #124, Individual #352, Individual #309, Individual #330, Individual #69, o Neurology Notes for the following individuals: • Individual #164, Individual #153, Individual #273 Individual #345, Individual #294, Individual #398, Individual #237 Individual #217, Individual #288 <u>Interviews and Meetings Held</u>: o Rebecca McKown, MD, Medical Director o Joel Bessman, MD, Primary Care Physician o John Burnside, MD, Primary Care Physician o Scott Lindsay, APRN, Family Nurse Practitioner o Jimmy Mercer, MD, Lead Psychiatrist o William Bazzell, MD, Staff Psychiatrist o Angela Garner, RN, Chief Nurse Executive o Lisa Owen, RN, Quality Enhancement Nurse <u>Observations Conducted</u>: o Daily Clinical Services Meeting o Medical staff meetings
	Facility Self-Assessment: The facility updated the POI on 11/22/11 and determined that it was not in compliance with any of the provision items for section L. This assessment was congruent with the findings of the monitoring team. The primary focus of the POI was the reporting of a series of status updates on the various initiatives for each provision item. Unfortunately, these status updates were not clearly linked to the provision items. For example, the updates for L1 addressed issues, such as the revision of the Quarterly Drug Regimen Review and the hiring of the clinical pharmacist. It failed to provide any information on how deficiencies

	cited in the last report, such as a lack of preventive screenings, outdated medical assessments, and outdated APLs were addressed. Moreover, important concerns related to the DNR process were never mentioned. The status updates for provision L3 did provide data, however, it was not clear how compliance rates of 90% for audits related to Provisions L and G resulted in a self-rating of noncompliance. An action plan was also provided for review. Notwithstanding self-ratings of noncompliance, the facility provided action plans for only provisions L3 and L4. The action plan for L3 did not define any real steps for creation of a medical quality program. Clearly, in order to achieve compliance with the Settlement Agreement, the facility will need to address and respond to all deficiencies noted.
	Summary of Monitor's Assessment: The monitoring team found noncompliance in all areas, but recognized that the medical staff of the facility was dedicated to serving the individuals supported by the facility. Although the results of this review found many gaps in the provision of care, the monitoring team noted many facility process and systems issues that contributed to these findings. The facility lacked adequate IT infrastructure to support databases for tracking essential information. Routing of consultations remained problematic and appeared to contribute to breakdowns in follow-up. A lack of stability in the pharmacy department resulted in QDRRs that provided a paucity of information on complicated drug regimens. Record reviews alluded to gaps in the appropriate notification of physicians regarding a change in status. Documentation by medical providers had made a small degree of improvement, but heavy caseloads likely impacted the ability to document frequently. There were some noteworthy improvements, but unfortunately, most of the changes had not had enough time for implementation to effect any detectable change. New clinical guidelines were issued by state office along with a new preventive care flowsheet. A daily, integrated clinical services meeting was implemented in October 2011 to bring many disciplines together to discuss relevant clinical issues. That meeting, however, occurred at the end of the workday, probably diminished the relevance of the meeting compared to it being held first thing in the morning. External reviews continued to be completed, but the focus of the reviews remained on processes without any meaningful assessment of clinical outcomes. While the facility conducted mortality reviews per policy, it appeared that follow up on recommendations remained problematic.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the documents reviewed section. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in sub-sections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Overview** The medical staff was comprised of a medical director, a full time primary care physician, and a full time advanced practice registered nurse. There was also a locum tenens physician who worked every other week, but primarily completed histories and physicals. The medical director did not carry a primary caseload. The nurse practitioner carried a caseload of 102 while the primary care physician carried a caseload of 139. The collaborative practice agreement for the advanced practice registered was signed on 11/14/11. According to the Texas Code cited within the agreement, protocols were to be reviewed annually, signed, and dated. The previous protocol was signed on 9/28/10. The facility conducted onsite ophthalmology, podiatry, and shoe clinics. The medical director had historically performed pelvic exams and pap smears. It was reported that this service had been interrupted due to the lack of a consistent clinic nurse since August 2010. During the last onsite review, the monitoring team was informed that a clinic nurse was to be assigned at the end of May 2011. The medial director reported again that "nursing issues" prevented clinic from occurring as required. Individuals who needed acute care and/or admission were usually admitted to the local Shannon Medical Center. Labs were drawn at the facility and sent to Shannon Medical Center. Results for routine labs were returned within one to two days while the results for stat labs were available in about two hours. A mobile x-ray company completed roentgenograms and a disc was provided for viewing immediately following completion. The images were capable of being viewed online provided adequate band length was available. After hours, roentgenograms were completed through emergency department assessment at the local hospital. This was a reasonable arrangement. Individuals who required neurology services were seen off campus. There was currently no process to have a joint neurology–psychiatry clinic. In October 2011, a daily clinical meeting was implemented that included participation by all physicians, nursing, and psychology. This meeting was intended to review relevant clinical issues. The monitoring team attended this meeting, which occurred at 4:30 pm	Noncompliance

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		each day. The discussions focused on clinical issues and events that occurred since the previous day. It appeared to provide some valuable information and served as a means of fostering collaboration between various disciplines, though its occurrence at the end of the workday, probably diminished the relevance of the meeting compared to it being held first thing in the morning. **General Medical Care and Documentation** Overall, individuals received basic health care and preventive services. Most individuals had timely vision and hearing screenings. There was good compliance with the administration of pneumococcal, yearly influenza, and hepatitis B vaccinations. Specialty services were provided through several local providers. Generally, the medical staff responded to the needs of individuals. Records reviewed, however, showed an array of problems related to follow-up of individuals with acute problems, follow-up of abnormal lab findings, and timely implementation of consultant's recommendations. Moreover, low levels of compliance were noted with several preventive care screenings, such as colorectal, breast, and cervical cancer screening based on the facility's self-reported data. Several of the requirements of the Health Care Guidelines are discussed below. Examples of findings related to the requirements are provided in the case reviews documented later in this section. <u>Annual Medical Assessments</u> Every record included in the record sample contained an Annual Medical Summary completed during the year 2011. This was a significant improvement from the previous two visits. The overall quality of information improved, too. The wellness and prevention section summarized preventive care and cancer screenings, and that was good to see. Even so, there was opportunity for improvement: • There was a section for management plans that included a plan for each of the active medical problems. Some providers included detailed information while other stated continue current management. • Several assessments contained data that were not current. There were instances in which a consultation or a diagnostic test was completed many months or a year before the assessment, but was not noted as the most recent assessment. • Although every record had a current AMS, several were not completed until many months after the PSP.	

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		• Problems were discussed separately. For example, an individual with a psychiatric diagnosis was prescribed Zyprexa. The individual was morbidly obese and had a diagnosis of diabetes. All of these issues were discussed separately and, at no point, was there a discussion of how the Zyprexa impacted the issue of obesity and diabetes and what, if anything, should be done to related to medication management of the psychiatric disorder. The medical director reported that there was no database for tracking compliance with the AMS data. She further reported that some summaries were done twice in order to get back in alignment with the PSP schedule. <u>Active Problem List</u> According to the Health Care Guidelines, "The active problem lists are specific forms that will be completed, kept current, and maintained in the record for all individuals." The active problem list will be updated as new diagnoses are made or as problems are resolved. At the time of an individual's annual team meeting the active problem list will be reviewed, revised, and dated to document changes that have occurred in the past 12 months." The facility's record index indicated that the APL was located under the Health Data tab. This was not listed as a separate document, but was noted to be printed on the annual physical. In fact, requests for copies of the APLs were fulfilled by copying the first page of the AMS, which contained a list of current medical problems. One record, however, contained a separate APL. The medical director will need to ensure that an Active Problem List is placed in each record. This document is independent of the AMS and must be updated as problems change. <u>Integrated Progress Notes</u> The entries in the IPN were usually in SOAP format, were signed, timed, and dated. <u>Documentation of Diagnostic and Laboratory Results</u> In most instances, labs were dated and initialed, but the records contained several documents that lacked evidence of the appropriate review. The IPNs contained few entries related to abnormal lab values and diagnostics. Several examples are provided in the case reviews. <u>Quarterly Medical Summaries</u> The medical director reported that Quarterly Medical Summaries continued to be completed by the locum tenens physician. Moreover, it was reported that the process had changed, such that the results of each summary were discussed with the primary provider. A review of records failed to demonstrate the presence of any recent	

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		summaries. An additional request for Quarterly Medical Summaries was made following the onsite review. For the record sample requested, only three QMSs were provided and all of these were completed four to six months prior to the review. There was no evidence that Quarterly Medical Summaries were completed in recent months. In several records, there was no medical provider documentation over a period of several months. State issued policy .009.1 Medical Care required "At least quarterly, all active problems, including chronic problems, will be reviewed. A Quarterly Medical Summary or a narrative note that addresses all of the elements will be used to document the review." Physician Orders Generally, when physicians wrote orders, they were signed, timed, and dated. There continued to be numerous verbal orders, but this appeared improved from the previous visits. Consultation Referrals Generally, consultation referrals contained the information required for the consultant to complete an evaluation. There continued to be problems with retrieval of official consults with primary providers making entries, such as "I need consult." Many consult reports were initialed weeks after the consult was obtained. This may have resulted in numerous delays is implementing changes in the care plans for individuals. It was reported that nursing maintained a database that tracked when appointments were scheduled, but this database was not shared with the medical department. Providers heard by word of mouth when scheduling was delayed. There was no formal process to notify providers of delays. Moreover, there was no data collected on turn around times for appointments to ensure that the provision of services occurred in a timely manner. Record reviews also revealed that providers were not consistently summarizing the content of the consults in the IPN within five working days as required by the Health Care Guidelines. The neurology communication policy was revised to include a requirement for the primary provider to write an order for the RN case manager to communicate or provide information to the PST for changes in status and/or plans that occurred as a result of the recommendations of the consultant.	

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		Routine and Preventive Care Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. Documentation indicated that the core vaccinations were usually administered to individuals. The Preventive Care Flowsheet should serve as a quick means of identifying the provision of basic preventive services. Record reviews revealed that the flowsheets were frequently not updated. In numerous instances, the monitoring team noted the PCFS listed the last screening as 2009 when the service was provided in 2010 or 2011. <u>Immunizations</u> • 14 of 14 (100%) individuals received pneumococcal and yearly influenza vaccinations The administration of pneumococcal, hepatitis, and yearly influenza vaccinations was clearly identified in the records. Younger individuals were frequently deemed not eligible for administration of the pneumococcal vaccination. Validation of varicella and zoster administration was sometimes difficult. Several of the more recent Annual Medical Summaries provided a concise summary of heath and wellness that included immunization data. The medical director should review the CDC guidelines for administration of pneumococcal vaccination and update protocols for administration. The CDC currently recommends vaccination for adults (1) > 65 years of age, (2) 19 – 64 years of age with chronic medical conditions, and immunocompromise, (3) cigarette smokers, and (4) residents of long term care facilities. The Health Care Guidelines required that all individuals residing at the facility receive one dose of the pneumococcal 23-valent vaccine according to the manufacturer's recommendations, unless medically contraindicated. <u>Screenings</u> • 14 of 14 (100%) records contained documentation of appropriate vision screening • 12 of 14 (86%) records contained documentation of appropriate hearing testing <u>Prostate Cancer Screening</u> • 4 of 7 males met criteria for PSA testing	

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		• 4 of 4 (100%) males had appropriate PSA testing <u>Breast Cancer Screening</u> • 3 of 7 females met criteria for breast cancer screening • 0 of 3 (0%) females had current breast cancer screenings A list of females age 40 and older, date of last mammogram, and reasons for noncompliance was provided. The list contained 43 individuals. • 18 of 43 (42%) individuals completed breast cancer screening in 2010 or 2011 • 4 of 43 (9%) individuals refused breast cancer screening • 3 of 43 (7%) individuals were cited as not appropriate for screening • 3 of 43 (7%) individuals had "risks outweigh benefits" as reason • 2 of 43 (5%) individuals completed in 2011, but results were "not located" • 2 of 43 (5%) individuals had "unknown" reasons • 7 of 43 (16%) individuals had no reason given for lack of screening • 4 of 43 (9%) individuals were either scheduled or had mammograms discontinued <u>Cervical Cancer Screening</u> • 5 of 7 females met criteria for cervical cancer screening • 3 of 5 (60%) females completed cervical cancer screening within the past two years A list of all females age 18 and older was provided. The list was titled mammograms, but it contained the names of 93 females, the date of the last pap smear, and explanations for lack of testing: • 50 of 93 (54%) females had documentation of cervical cancer screening between the years 2009 and 2011 • 43 of 93 (46%) had no documentation of cervical cancer screening or screening, or had screening that was completed prior to 2009. The following explanations were provided: o 3 of 93 (3%) females had undergone hysterectomies o 10 of 93 (11%) females were either new admissions or had pending exams o 12 of 93 (13%) females were cited as " NSA" – needs sedation/anesthesia o 3 of 93 (3%) individuals were deemed to have negative risk benefit profiles o 6 of 93 (6%) females had screenings discontinued o 9 of 93 (10%) females had other reasons cited	

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		Colorectal Cancer Screening • 7 of 14 individuals met criteria for colorectal cancer screening • 4 of 7 (57%) individuals had undergone colonoscopy for colorectal cancer screening A list of individuals, age 50 and older, was provided. The list contained 90 individuals. • 35 of 90 (39%) of individuals had completed colonoscopies within the last 10 years • 55 of 90 (61%) of individuals had no documentation of colonoscopy with the following explanations: o 33 of 90 (37%) individuals "risk-benefit not appropriate" o 9 of 90 (10%) individuals required follow-up to determine if procedure was ordered and completed o 4 of 90 (4%) individuals refused colonoscopy o 5 of 90 (6%) individuals had colonoscopies ordered o 1 of 90 (1%) individuals had reason "not ordered" o 3 of 90 (3%) individuals documented other reasons **Medical Management** Diabetes mellitus The facility provided a list of 36 individuals who were diagnosed with diabetes mellitus. Some individuals, however, did not appear to actually have a diagnosis of diabetes. Five records were reviewed for compliance with standards set by the American Diabetes Association: (1) monitoring of HbA1c, (2) glycemic control (HbA1c<7), (3) use of ACE/ARB, and (4) monitoring for diabetic nephropathy: • 5 of 5 (100%) individuals had adequate monitoring of HbA1c • 5 of 5 (100%) individuals had adequate glycemic control • 1 of 5 (20%) individuals received treatment with an ACE inhibitor • 3 of 5 (60%) individuals had some form of urine microalbumin documented o 1 individual had no documentation of urine microalbumin The Preventive Care Flowsheet included a section to record diabetes management, but this section of the document was usually not completed. Osteoporosis A list of all individuals with a diagnosis of osteoporosis and osteopenia, medication regimens, and the date of the last DEXA scan was requested. The monitoring team was provided with a list of individuals with the diagnosis of osteoporosis and the date of the	

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		last DEXA. Information related to treatment was not provided. <u>Constipation</u> A list of individuals with the diagnosis of constipation was provided. The list contained 127 individuals. The drugs used to treat constipation were not included in the listing. Rather, several hundred pages of drug monographs were provided. One notable finding in the drug monographs was that many individuals who were cited as having chronic constipation received no medication related to the diagnosis. In many instances, these individual received other medications associated to constipation. Other data related to non-pharmacologic bowel management was unknown. <u>Pneumonia</u> The facility provided a list of 12 individuals who were diagnosed with pneumonia in 2011. The facility should review these data to ensure that it captured all pneumonia events. For example, Individual #206 was diagnosed with pneumonia in January 2011, but the event was not captured in the report provided. The facility also reported almost all pneumonias as bacterial. Many of the individuals diagnosed with pneumonia, however, had multiple risk factors for aspiration. It is critical that the medical director ensure that individuals at risk for aspiration have all necessary supports in place. Each episode of pneumonia should be carefully reviewed to determine the likelihood that an aspiration event occurred. The appropriate and aggressive supports should be implemented to minimize reoccurrence. See Section L3 for further discussion. **Case Reviews** Individual #330 had a history of diabetes mellitus, seizure disorder, hydrocephalus, menorrhagia, tachycardia and obesity. The following observations were made through record review: • Vision and hearing screenings were completed in 2011. • Pneumococcal, influenza, and varicella vaccinations were provided. • Cervical cancer screening was completed. • The QDRR was completed 9/14/11. • The Preventive Care Flowsheet was not current. • A CBC from 7/20/11 noted an MCV of 79.4, Hb of 11.6, and Hct 34.7. The report contained comments on the etiology. There was no follow-up study ordered nor was any additional testing done to determine the etiology. A hematology consult completed on 9/20/11 recommended obtaining iron studies, but this was not obtained until November 2011. The individual had marked iron depletion with a ferritin of 7. The repeat CBC showed Hb/Hct of 12.5/38.3. Iron supplementation was started two weeks later.	

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		• The AMS noted that a vaginal ultrasound was performed on 4/20/11, but was not available in October 2011 at the time of annual assessment. • Diabetes management – Glucose was well controlled on metformin. The HbA1c was periodically monitored. • It is not clear why the diagnosis of severe iron deficiency took four months to diagnose. The initial assessment could have been completed by the primary provider before hematology consultation. The manifestation of iron deficiency occurs in stages and iron stores can be depleted prior to the onset of actual anemia. Given this was such a straightforward problem, a four month delay in treatment seemed unwarranted. Individual #309 had the diagnoses of diabetes mellitus, hyperlipidemia and: • Vision and hearing screenings were completed in 2011. • Influenza and hepatitis B vaccines were administered. • There was no cervical cancer screening documented • A prolactin level on 1/24/11 was 74.54 and the report commented that the individual was on Zyprexa. There was no follow-up prolactin level in the record. Additional monitoring of this high level of prolactin was indicated. Individual #69 had a history of hyperprolactinemia, obesity, insulin resistance, seizure disorder, hypothyroidism, and GERD: • Vision and hearing screenings were current. • Pneumococcal, varicella, and influenza vaccines were administered. The individual appeared to be a non-responder to vaccination against hepatitis B. • Cervical cancer screening was completed in 2010. • QDRR 10/14/11 stated, "see QDRR 7/2011" The primary provider signed on 12/1/11 and noted that the July 2011 was not available. • The prolactin was 75.36 on 3/ 23/11. On 10/17/11, the prolactin was 88.4. The provider note on 10/24/11 stated that the result was forwarded to the psychiatrist. Individual #225 had multiple medical problems, including a history of hypertension, seizure disorder, hyperlipidemia, and diverticulosis. Observations noted related to care included: • On 12/5/11, 2:10 am: Nursing noted that the individual had three loose stools since 2230 on 12/4/11. Vital signs were BP 123/82, HR 54, RR 18, T 98, and O2 sats 97%. Kaopectate was ordered, and the staff was to notify the nurse of any concerns. • 12/6/11 9:45 am: Staff notified nurse and MD that individual had fallen back onto the couch after standing up suddenly. Doctor examined individual and	

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		attributed event to diarrhea and dehydration. Vital signs were BP 95/60, HR 56, RR 18, and T 97.8. Skin tenting was documented. Gatorade was ordered along with increased monitoring of vital signs. o 10:00 am: BP 86/52: Resting in bed, alert, and drinking Gatorade. o 10:15 am: BP 92/50: alert and cooperative; continues to drink. o 10:30 am: Alert and responsive; BP 90/56. o 10:45 am: Resting in bed; responsive to verbal stimuli, BP 88/52. o 11:00 am: Ambulatory to shower room, to shower, BP 94/56. o 2:00 pm: Individual noted to be sitting up, but nurse was unable to obtain BP with manual cuff. "He seems unsteady and doesn't look right." RN notified of continued low BPs. o 14:30: Awake and oriented; vital signs - BP 86/52, HR 71, RR 22, O2 sats 90%, and T 96.8. o 9:30 pm: Alert and oriented; vital signs – BP 89/58, O2 sats 96%, HR 76. o Untimed entry: Nurse documented that she went into room and found individual unresponsive; activated code system and began CPR. o 10:30 pm MD entry: Called at 9:10 pm to see individual; at 9:15 pm CPR in progress. Code called at 9:17 pm as individual was obviously dead. • A review of progress notes revealed that at no point during the 19 hours prior to death was there any documentation of a physician assessment. The individual had a history of loose stools, a history of possible near syncope, and was noted to have hypotension with blood pressures significantly lower than baseline blood pressures documented in the records. The individual's blood pressure did not show any significant improvement during the hours preceding death. The Health Care Guidelines required that an assessment of an individual with an acute medical problem include a comprehensive history, documentation of information source, pertinent physical findings, results of diagnostic testing, a differential diagnosis and a plan for further evaluation, treatment, and monitoring. Additional follow-up assessments must be documented until problem resolution or stabilization. Specific orders must be written detailing the monitoring that PCP expects from nursing staff for ongoing assessment of the acute problem. The care provided for Individual #225 was not consistent with this standard. Individual #109 had a history of seizure disorder, hypertension, CVA, GERD, and dementia: • Vision and hearing screenings were completed.	

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		• Pneumovax, influenza, hepatitis B, and varicella vaccinations were provided. • Colorectal breast and cervical cancer screenings were all discontinued. • The AMS was current, but done five months after PSP. • Data contained in the Preventive Care Flow sheets was not updated. • The neurology consultation, 3/5/10, documented advanced dementia and good seizure control. The neurologist noted, "Does she need to continue Keppra?" The consultant also commented that Baclofen was of little benefit to the individual and follow-up PRN was recommended. The AMS dated 5/12/11 specifically documented continuing the Baclofen and Keppra along with follow-up neurology follow-up. There was no documentation why the neurology recommendations were not followed. • An abnormal urinalysis report, dated 11/15/11, was not signed or dated by the provider. Abnormal labs dated 11/19/11, were not noted in the IPN. • There was no current QDDR in records. The most recent two were dated 3/22/11 and12/22/10. • The MOSES evaluation had no review date. The primary provider signed, but there was no conclusion. • The DISCUS, dated 9/27/11, indicated persistent TD. • Documentation of the individuals health status was very infrequent even when the individual experienced acute medical problems: o On 6/20/11 at 10:30 am, the primary provider assessed the individual for wheezing. Orders were written for treatment and to continue to monitor for changes. There was no follow-up documentation by the primary provider on this issue. o On 10/3/11, the primary provider evaluated the individual following a seizure and wrote orders to obtain a Keppra and Tegretol levels and to monitor. There was no documentation or follow-up noted related to the AED levels. o On 11/14/11 at 4:30 pm, there was nursing documentation related to the individual being incontinent and needing to stay in bed as wheelchair was cleaned. o On 11/15/11 at 9:10 am, there was a note by a primary provider stating the individual required transfer to Shannon Hospital due to a drop in blood pressure (70/30) and unresponsiveness. o On 11/18/11 at 5:15 pm, the primary provider wrote a post hospital note indicating the individual returned from the hospital with a diagnosis of E. coli urosepsis. The records contained no further documentation from the medical providers. The Health Care Guidelines required documentation of daily monitoring for at least the first 48 hours after discharge with periodic monitoring afterwards	

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		appropriate to the situation. Individual #203 had the diagnoses of seizure disorder, hypothyroidism, GERD, asthma, and tachycardia • Vision and hearing exams were current. • Pneumococcal, influenza, and hepatitis B vaccinations were administered. The varicella status was not clear. • Cervical, breast and colorectal cancer screening was not current. • On 9/17/10, the individual was seen by the neurologist due to "continued seizures." The recommendation was made to titrate Topamax from 100 mg BID to 200 mg BID and return to clinic in March 2011. At some point, the dose was increased to 150 mg BID. On 6/14/11, a physician order indicated that a Topamax level was needed for clinic appointment on 6/17/11. At 1:30 pm, an order was written to cancel neurology appointment and re-schedule in two months. An order was also written to increase the Topamax to 200 mg BID. The follow-up appointment was completed on 8/19/11 at which time the neurologist recommended a CT scan of the brain as well as an EEG. These recommendations were not summarized in the IPN. Furthermore, orders to obtain the studies were not written until 9/23/11. Individual #206 had multiple problems including seizure disorder, GERD, osteoporosis, dementia, history of CVA, cataract removal, and renal calculi. • Vision and hearing screenings were completed in 2011 • Pneumovax, influenza, and hepatitis B vaccinations were provided. • Cervical, breast, and colorectal cancer screenings were not current. ` • Consultation referrals were completed appropriately • The QDRR did not have a date, but was noted to be for the review period ending July 2011. Pharmacy comments related to nasal steroid use (A), but this QDRR was initialed on 10/3/11. The other included QDRR was dated 3/24/11 and was stamped received on 5/19/11. • On 1/1/11, the individual had a CXR done due to cough, congestion and fever. The chest x-ray showed a left base infiltrate, and the individual was sent to the emergency department for evaluation around 12 noon and returned a few hours later. Levaquin was prescribed. There was no medical exam or assessment found in the records nor was there any follow-up assessment. o On 1/4/11, the RN case manager contacted the primary provider and reported that the individual looked ill. The provider documented shortness of breath and wheezing. The symptoms improved with administration of nebulizer treatments. o On 1/6/11, the provider note indicated follow-up of pneumonia and	

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		that individual was improved. A CT scan of the chest was completed that day. There was no IPN documentation of the CT report. • The individual was seen in neurology clinic on 5/6/11 at which time the neurologist recommended a f/u brain CT, EEG, and tapering of Depakote (due to elevated ammonia), starting Keppra and returning to clinic in four months. The Depakote at the time of the clinic evaluation was 500 mg BID. The recommendation was to taper to 750 mg qhs x 2 weeks, 500 mg x 2 weeks, 250 mg x 2 weeks, and then discontinue. o The individual was sent to the ER for seizure activity on 7/14/11 and was also diagnosed with a UTI. Upon return from the ER, the MD documented that Depakote would be increased from 500 mg bid to 500 mg tid and neurology consulted the next day. It appeared that the original taper never occurred. The antibiotics prescribed were not administered. • On 9/14/11, the individual was sent to the emergency department due to fever and lethargy. Based on documentation, this presentation was abrupt. The individual was hospitalized until 9/20/11 with a diagnosis of pneumonia. The primary provider evaluated the individual upon return and a note was written. The note, which was not in SOAP format, briefly summarized the hospitalization. There was no information regarding the risk of aspiration or if this sudden onset could have been attributed to aspiration pneumonia. There were subsequent primary provider notes on 9/21/11 and 9/23/11 and all documented that the individual was doing well and responding to treatment for community acquired pneumonia. Individual #274 had the diagnoses of seizure disorder, morbid obesity, amenorrhea, diabetes mellitus and obstructive apnea. • Vision and hearing screenings were completed in 2011. • Pneumococcal, influenza, and hepatitis B vaccinations were administered. Cervical cancer screening was current, although the AMS did not have current data. • The individual was seizure free since 2004. A neurology consult dated 1/15/10 stated that the individual could be considered for terminal tapering of the AED. The individual told the neurologist that the guardian would not allow that. The neurologist documented in the consult that, if this was accurate, there was no reason to follow up in clinic. The AMS plan related to seizure management did not discuss discontinuing the AED nor did it indicate that a discussion occurred. The individual had been seizure free for seven years. • The individual was treated for diabetes with metformin. Glucose was well controlled. The length of the diagnosis was not known, but the individual did	

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		not receive an ACE/ARB for renal protection nor was there any documentation of urine microalbumin. • On 10/1/11, the individual complained of draining sinuses. A verbal order was given for Sudafed and Mucinex. There was no MD evaluation. The symptoms persisted for days and symptomatic treatment was provided. On 10/13/11, the individual was referred to the MD for follow-up. A CBC was ordered and ibuprofen was administered for a temp of 103.8. The first primary provider noted was dated 10/14/11 at 8 am. On 10/18/11, the primary provider noted that the CXR showed marked cardiomegaly and the individual was sent to the emergency department for evaluation. The individual was admitted and diagnosed with, bilateral pulmonary emboli, elevated lithium levels, and dehydration. Following return to the facility on 10/26/11, the primary provider entered a post hospital note in the IPN. The next medical entry was on 10/28/11, which noted some confusion regarding nursing's perception of physician availability. The next medical entry was 10/31/11. **Do Not Resuscitate** A request was made for a list of all individuals with a current DNR order, reason for DNR, date of implementation and subsequent renewal dates. A list of 15 individuals was provided. The list contained the category (the level) and the original implementation date. The list did not state the reason for the DNR nor did it list follow-up assessment dates. During the May 2011 visit, the monitoring team surfaced concerns relate to the long-standing nature of several DNRs. It was further suggested that the facility review the list of individuals with DNRs and rescind those that did not meet the criteria of the recent state issued policy. That recommendation was not discussed in the POI or action steps. The DNR process will need to be further evaluated at the next review. **Seizure Management** Individuals were seen at a local medical facility. Generally, the care provided appeared to be valuable and comprehensive. In order to improve communication between primary care providers, psychiatrists, and the neurologist, the facility maintained a procedure for obtaining input from the medical staff for inclusion on the consult form. Following return from the neurologist, the reports were routed to the primary providers and psychiatrists (when appropriate). Providers were expected to document receipt of, and acceptance or denial of, the consultant's recommendations in the IPN. Records reviewed did not demonstrate that this was consistently done. There continued to be no effective means of achieving appropriate neuropsychiatric consultation. A listing of individuals with the diagnosis of seizure disorder was requested. This	

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		document contained the names of 76 individuals with a diagnosis of seizure disorder and the medications used for management of seizure disorder. With regards to AED polypharmacy: • 12 of 76 (16%) individuals received 0 AEDs • 64 of 76 (84%) individuals received AEDs o 50 of 64 (78%) individuals received 1 AED o 11 of 64 (17) individuals received 2 AEDs o 3 of 64 (5%) individuals received 3 AEDs • 7 of 64 (11%) individuals received at least one older more toxic AEDs The facility calculated polypharmacy rates were significantly lower because the rates were based on the entire census of 238. The polypharmacy rates should not be based on individuals who are not treated for seizure disorder. The clinic records for 10 individuals were reviewed along with all neurology clinic notes included in the record sample. The clinic notes were relatively detailed and provided information on drug doses, type of seizure activity, number of seizures, drug side effects, and lab results. Consultations lacked information related to screening for osteoporosis associated with AED use and supplementation with calcium, vitamin D, and folic acid. The consults also did not include any information from the side effect evaluation tools completed by the facility. The notes consistently addressed the issue of AED polypharmacy and discontinuation of medications for individuals who were seizure free for long periods of time. There were several occurrences in which the recommendations from the neurologist were not implemented for several months. Specific examples were provided above in the case reviews.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Medical Reviews</u> The second external medical audit was completed in June 2011. A team of providers from other SSLCs conducted the review. During the conduct of each review, a five percent sample of records was examined for compliance with 32 requirements of the Health Care Guidelines. In order to obtain an acceptable rating, all essential items were required, in addition to receiving a score of 80% on nonessential items. In June 2011, the facility also began completing internal audits utilizing the external audit tool. Four charts were reviewed each month and results provided to the medical director. Ratings on essential items ranged from 68 to 93 percent, and from 92 to 95 percent for nonessential items. The results of the June 2011 external audit related to the essential elements differed significantly from the findings of the first four internal audits. This may have ben due to sample selection. Nonetheless, the facility will need to ensure that there is consistency	Noncompliance

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		in the methodology of audit completion and establish inter-rater reliability. The medical director reported that the results were discussed with the primary providers. The QA Department developed action plans and the QA nurse completed follow-up. QA documents dated 11/1/11, noted the following status of the action plans:	

	Total Action Plans	Total Reviewed by QA	Remaining to Review by QA	Action Plans Completed	Remaining to Complete
Provider 1	15	13	2	5	10
Provider 2	6	6	0	6	0
	21	19	2	11	10

The majority of the outstanding action plans related to failure to update the annual medical summaries and update the problem lists. Deficiencies remained relative to unsigned and undated orders, and progress notes.

All of the audits conducted focused on process indicators related to compliance with policy and procedure and documentation. There was no assessment of clinical outcomes or the actual medical care provided by the medical staff. For example, the facility had some 36 individuals listed as having a diagnosis of diabetes mellitus. None of the audits completed actually assessed if the care was consistent with the standards set forth by the American Diabetes Association or other determined standards of care. Similarly, there was no assessment of the medical management of individuals with osteoporosis or hypertension. The medical director reported that the external audit tool had been revised to capture clinical outcomes and the revised tool would be used during the March 2012 external audit.

Mortality Reviews

The facility conducted mortality reviews per state policy. There were two deaths since the last onsite review. One death occurred during the conduct of the May 2011 review.

Mortality documents were requested for all deaths since the last review. Copies of documents for the most recent death were provided. The clinical and administrative death reviews occurred per state policy. Documents reviewed indicated no unusual circumstances surrounding the death. This appeared to be a very elderly individual who experienced a sudden cardiac event.

The QA Nursing report surfaced issues related to the provision of care several months prior to death. While these factors did not play any role in the death, they spoke to the issue of problems identified with documentation of adequate assessments and follow-up when individuals experienced acute medical problems. The clinical death review included recommendations for retraining medical and nursing on documentation. The

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		file did not provide updates on corrective actions related to medical training. A corrective action plan for nursing was generated by the QA Department. The log documented that, as of October 2011, information on the status of the corrective actions had not been provided. Facility leadership must ensure that recommendations related to mortality reviews are appropriately implemented and followed up. In this case, the findings were not issues related to the death of the individual. Nonetheless, the issue of failing to provide adequate follow-up under different circumstances may have the ability to seriously and adversely impact clinical outcomes.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The medical director reported that quality was measured through the external medical reviews. This measurement of quality was augmented by the internal audits that were completed by a locum tenens physician. Audit tools had been developed to monitor requirements related to documentation for emergency department visits, hospitalization and consultation referrals. There were no data available related to these audits at the time of the onsite review. QI Council minutes documented that the facility would be reporting the number of hospital and ER visits, and the presence of supporting documentation related to the visits. The facility had not developed any local policy for a medical quality program. As previously mentioned, all of the audits that were conducted focused on processes. There was no attention given to the actual clinical outcomes. Even in those instances where data were generated on process outcomes, there appeared to be a lack of adequate resolution of outstanding issues. There were numerous opportunities to assess the quality of care provided, a simple one being determination of the quality of care provided to persons with the diagnosis of diabetes. Given the significant number of individuals reported to have this diagnosis, a review of the provision of medical care to these individuals provided an excellent opportunity to assess medical quality and implement improvement activities for a disease associated with significant morbidity. Development of extensive protocols would not be necessary because the standards set forth by the American Diabetes Association are widely accepted. Development of a facility protocol would not be difficult. The Preventive Care Flowsheet listed many of these standards, but the documents were not routinely completed. The facility developed a pneumonia Performance Improvement Team. The overall goal of the PIT was to identify risks and implement strategies to prevent pneumonia and aspiration syndromes. The PIT also attempted to determine the rate of pneumonia for the facility and make some general comparisons to national standards.	Noncompliance

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		The facility reported 12 cases of pneumonia in 2011. Most of these were classified as bacterial pneumonia. The monitoring team noted, through record reviews, that following the diagnosis of pneumonia, there was no overall review of the case to better define if the pneumonia was related to aspiration. Most of the individuals with a diagnosis of pneumonia had multiple risk factors for aspiration. The PIT proposed the use of a checklist to review every case of pneumonia. The checklist would attempt to better define an individual's risk and determine the likelihood of an aspiration event. The monitoring team suggested that the facility develop a process to ensure that every episode of pneumonia is captured. This may involve a monthly review of multiple data sets, such as a list of all individuals who received antibiotics for the diagnosis of pneumonia. This is necessary because not all individuals with a diagnosis of pneumonia are hospitalized or sent to the emergency department. The facility should also develop the appropriate metrics for monitoring disease. Incidence rates are a direct measure of risk (probability) that healthy people will develop a disease or condition during a specified period of time. It is the rate at which new disease occurs in a defined previously disease-free group of people. It is a helpful tool to study causality or etiology of disease: # new cases of disease or condition/ total # in population at risk for the disease or condition. Prevalence rates measure disease burden or the number of people in the total general population who have the disease at any given time: # of existing cases of a disease/# in the total population. The most helpful metric for the facility would be the incidence rate. The caveat is that the incidence of aspiration pneumonia in the literature is variable. Further analysis of pneumonia trends could include stratification by age. The PowerPoint presentation provided detailed information on pneumonia, although it seemed somewhat complex for the average audience. The monitoring team believes that a simple combined clinical classification of pneumonia would be appropriate. This widely utilized classification scheme classifies pneumonia as community acquired and hospital acquired. A third and relatively new classification of healthcare-associated pneumonia falls between the other two. The fourth category of pneumonia would be aspiration pneumonia. Developing protocols based on this classification would likely be helpful to practitioners. The development of a medical quality program requires that clinical guidelines and protocols be developed and expected clinical outcomes be established. This is discussed further in Section L4.	

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L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	State office issued several policies since the last onsite review. The Preventive Health Care Guidelines were issued on 8/30/11. These guidelines were detailed, comprehensive, and covered a wide scope of health services. They included a standardized preventive care record that allowed for documentation of cancer screenings, infectious disease screening, immunizations, etc. This document, intended for inclusion in the record, however, did not provide any guidelines for the screenings. The providers would need to reference the actual policy to ensure compliance. The guidelines provided detailed guidelines from the United States Preventive Services Task Force (USPSTF). For example, the policy stated the "The USPTF found no direct evidence that annual screening achieves better outcomes than screening every three years." It also documented "ACOG guidelines to begin pap testing at age 21, be screened every 2 years through age 30, and then be screened every three years as long as the last three results were normal." Following discussion of the various screenings, a final set of recommendations was made. With regards to cervical cancer screening, the recommendation was to attempt a pelvic exam and pap smears at age 21 and annually thereafter in woman at risk for cervical cancer and vaginal cancer (those who have been sexually active and have a cervix). The Health Care Guidelines used the age of 18 as the starting point. While the policy contained good information, the monitoring team found difficulty in determining the actual recommendations due to the fact that multiple sources and recommendations were included. In addition to the Preventive Health Care Guidelines, the monitoring team was provided numerous other documents that contained guidelines for prevention. The document, Major Recommendations, provided guidelines for preventive health care. It recommended cervical cancer screening begin at age 21 and continue every one to three years at the physician's discretion. The Lab Matrix provided yet another set of criteria for cervical cancer screening. The monitoring team was provided with copies of state issued protocols on aspiration, seizure management, enteral feedings, bowel management, and seizure instructions for the PCP. These protocols were provided as a series of independent documents. They were not linked to any state issued or local policy. The expectations for how the medical providers were to use these protocols were not clear. The medical director stated that the protocols had been finalized and were implemented. The monitoring team offers the following recommendations for consideration with regards to the generation of the clinical protocols: • The issue of disease prevention and management could be addressed through one overarching policy, or through separate polices. One of these policies could	Noncompliance

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		call for the generation of a Disease Prevention and Management Flowsheet. The first part of the flow sheet could address basic preventive services. In order to increase compliance with the guidelines, the flowsheet should indicate when the services should be provided. The second part of the flowsheet could include data for common diseases categories, such as diabetes, hyperlipidemia, hepatitis, and hypertension. The component of the policy that addressed disease management would refer to the individual disease management protocols that would be included as policy/guideline attachments. As protocols were developed, the policy would need simple updating to reflect the additions. • Regardless of the method chosen, any policy on preventive care should clearly identify the adopted guidelines. The source of the guidelines should be referenced, but it should not be necessary to detail the recommendations of the various sources within the context of the guidelines. • All policies, procedures, guidelines, and protocols should be consistent. It is clearly understood that medical providers have the obligation to deviate as clinical judgment dictates for each individual. The development of a medical quality program will require that clinical outcomes be defined in the clinical protocols. While the facility can assess the quality of some aspects of medical care based on data currently being collected, full implementation of a robust medical quality program will require that the clinical outcomes cited in the various guidelines be consolidated.	

Recommendations:

1. The medical director must be responsible for compliance with Texas Code with regards to the collaborative agreement between the APRN and physician (L1).

2. The medical director should consider conducting the daily clinical meeting during the morning, if possible. Conducting a morning meeting provides an opportunity for staff to gain information related to events that occurred after the business day. This, in turn, provides staff with the ability to address important clinical issues at the start of the day (L1).

3. The Annual Medical Summaries should be completed in alignment with the PSPs. The medical director should discuss with the medical staff the need to provide accurate and current information. It might also be helpful in planning a comprehensive plan for the primary providers to include a discussion of risks and how those are addressed. (L1).

4. A tracking mechanism must be established to ensure that Annual Medical Summaries are completed in a timely manner (L1).

5. The medical director should ensure the Active Problem List is completed in accordance with the Health Care Guidelines. This is a specific form

that must be updated as new diagnoses are made or as problems resolve (L1).

6. All labs and diagnostics should be reviewed, dated, initialed, and addressed by the medical provider in accordance with the Health Care Guidelines (L1).

7. Primary providers should complete Quarterly Medical Summaries. The medical staff should develop a standardized template to include all elements required by the Health Care Guidelines (L1).

8. The use of verbal orders should me minimized (L1).

9. The facility should track all consults to ensure that appointments are made in a timely manner and providers receive the official consults promptly. This information should be shared with the medical director and medical staff. It should also be available tor those responsible for records management (L1).

10. The medical staff should address consultation recommendations within five days. The primary provider should document in the IPN the rationale associated with the decisions whether to implement the recommendations (L1).

11. The Preventive Care Flowsheet should be updated on a regular basis (L1).

12. The medical director should review CDC vaccination guidelines and ensure that the facility protocols are current (L1).

13. Preventive screenings should be completed in accordance with the facility's medical and preventive health care guidelines. When the recommendations are not followed, the primary provider should provide a clear explanation in the progress notes as well as the Annual Medical Summary of why the guidelines were not followed. The phrase "risks outweigh the benefits" in itself is not an adequate explanation for not providing preventive screenings.

14. The medical director should ensure follow-up on issues documented in the case reviews (L1).

15. The medical director should discuss with the medical staff the requirements, as outlined in medical policy, for management of acute medical problems. This discussion should include the requirement that follow-up assessments be documented until the problem resolves or is stabilized (L1).

16. The facility should ensure that all persons with a current DNR order have been appropriately evaluated and that all DNR orders have been implemented in accordance with state policy (L1).

17. With regards to the provision of neurological services, the following actions are recommended:
    a. Primary providers should ensure that all individuals receiving AEDs have appropriate screening for osteoporosis, and assessment of the adequacy of calcium, Vitamin D and folic acid.
    b. The medical director should review and correct AED polypharmacy data. Particular attention should be given to ensuring that all persons who are candidates for tapering of drugs and discontinuation of medications receive appropriate assessment.
    c. The MOSES and DISCUS evaluations should be included in the transfer packet that is provided to the consulting neurologist.

18. The following recommendations are offered with regards to the medical review process:
    a. The medical director, in collaboration with the quality department, should ensure that appropriate methodology is used in completion of internal medial audits. This should include determination of inter-rater reliability.
    b. Professionals with appropriate credentials should complete medical audits. The determination of the adequacy of care related to clinical outcomes will require review by a clinician with expertise in clinical medicine.
    c. The medical director should develop corrective action plans for deficiencies noted in the internal medical audits. Documentation of the status of the plans should be maintained.
    d. The medical director should review the current status of the action plans related to the external audits (L2).

19. The facility director should ensure that recommendations generated from mortality reviews are implemented and appropriately followed –up.

20. The facility should continue efforts related to the Pneumonia Performance Improvement Team:
    a. The PIT should determine the appropriate metric to measure improvement.
    b. The PIT should determine how to best capture all episodes of pneumonia so that data is accurate.
    c. Efforts targeted to better defining the type of pneumonia should continue.
    d. Protocols generated by the PIT should be reviewed to ensure consistency with state generated protocols (L3).

21. Given the significant number of persons with the diagnosis of diabetes, the facility should use current information to determine the quality of care provided to persons with the diagnosis of diabetes mellitus (L3).

22. The medical director will need to ensure that the medical staff have clear guidelines regarding the provision of services and implementation of clinical protocols and guidelines. This will require that all policies, procedures and guidelines be reviewed for consistency and revised as appropriate (L4).

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o SGSSLC Organizational Chart o Map of SGSSLC o DADS State Supported Living Center Policy: Nursing Services (1/31/10) o DADS State Supported Living Center Policy: Guidelines for Comprehensive Nursing Assessment (July 2010) and Comprehensive Nursing Assessment form (June 2010) o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o A list of all individuals served by residence/home, including for each home an alphabetized list of individuals served, their age (or date of birth), date of admission, and legal status o A list of individuals admitted within the last six (6) months and dates of admission o The agenda for new staff orientation o The curricula for new staff orientation, including training materials used o The schedule for ongoing in-service staff training o The curricula for ongoing in-service staff training, including training materials used o For nursing, the number of budgeted positions; the number of staff; the number of contractors; the number of unfilled positions, including the number of unfilled positions for which contractors currently provide services; and the current FTE o Lists identifying each individual who is identified to be "at risk" utilizing the State's risk categories o Since 5/1/11, individuals who have been seen in the ER, including date seen and reason for visit o Since 5/1/11, individuals admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es), and date of discharge from hospital o Since 5/1/11, individuals admitted/transferred to the Facility's Infirmary, including date of admission/transfer, reason for admission/transfer, and date transferred back to home unit o Since 5/1/11, individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia (e.g., aspiration, bacterial, etc.); and/or have had a swallowing incident, including the date of incident, item that caused the swallowing incident, and the interventions following the incident o Nursing staffing reports/analysis generated in the last six months o Minutes of the Infection Control Committee for the last six months o Minutes of the Environmental/Safety Committee for the last six months o Minutes of the Department of Nursing meetings for the last six months o Minutes of the Nutrition Management Committee for the last six months o Minutes of the Pharmacy and Therapeutics Committee meetings for the last six months o Minutes of the Medication Performance Improvement Team meetings for the last six months o All SGSSLC policies and procedures addressing emergency/code blue drills o SGSSLC training curriculum for the implementation of emergency procedures including training materials

	o All emergency/code blue drills, medical emergency reports, including tracking logs, recommendations, and/or corrective actions based on these reports/analyses for the last six months o List of SGSSLC staff who are certified in first aid, CPR, or ACLS with expired certification o Documentation of annual consideration or resuming oral intake for each SGSSLC individual receiving enteral nutrition o All SGSSLC training curricula on infection control, including training materials o SGSSLC infection control surveillance and monitoring reports for the last six months o SGSSLC nursing audits, data, analysis reports for the last six months o SGSSLC medication administration audits and reports for the last six months o List of individual who died at SGSSLC or after being transferred to a hospital or other care setting for the last six months o SGSSLC Self-Assessment: POI 11/22/11 o SGSSLC Meeting Schedule updated 12/5/11 o Copy of Medication Over/Short form o Draft policy of Assessment after Allegation of Sexual Incident o Inter-rater reliability scores for 12 nursing monitoring tools by section by tool o Minutes from all Enteral Nutrition, Pneumonia, and Medication Variance PIT meetings o Corrective Action Plans developed in response to recommendations from QA death review o Consultation Process policy o Draft "Proposal for Staffing Development" o 30-Day QA Review of Individuals #278 and #109 o QA Nurse's reports of Medication Variance o QA Nurse's review of medication rooms 6/11-11/11 o Nursing Organization Chart, updated 12/7/11 o Daily Nursing Staff Matrix for 6/1-12/1/11 o Records and MARs of: • Individual #288, Individual #217, Individual #22, Individual #151, Individual #173, Individual #90, Individual #81, Individual #339, Individual #97, Individual #162, Individual #331, Individual #122, Individual #318, Individual #78, Individual #189, Individual #294, Individual #278, Individual #163, Individual #222, and Individual #313 <u>Interviews and Meetings Held</u>: o Nursing Operations Officer, Lisa Busby o Quality Enhancement Nurse, Lisa Owen o Nurse Hospital Liaison, Melanie Nealey o Nurse Educator, Jenni Price o Infection Control Nurse, David Ann McKnight o Infirmary RN, Regina Haight o PNMT RN, Maria DeLuna o Director of CT&D, Connie Terhar o Director of Habilitation, Dena Johnston

	o Medical Provider Meeting o Nursing Management/ "Hot Spot" Meeting o Medication Performance Improvement Team Meeting o Informal interviews with 8 nurses (included RN case managers, RNs, and LVNs) o Informal interviews with 5 direct care staff members o PSPA for Individual #76 <u>Observations Conducted</u>: o Visited individuals residing in buildings 504A, 504B, 509B, 510A, 510B, 511A, 511B, and 516W o Medication administration - 504A, 504B, 509B, 510A, 510B, 511A, 511B, and 516W o Enteral nutrition - 516W and 504A
	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. It was updated on 11/22/11 and was separated into two sections. The first section consisted of lists of discrete events, usually trainings, monitoring activities, and policy revisions, in accordance with state directives, across all provisions of section M that had occurred over the past year. The second section referenced some specific actions that were expected to help the Nursing Department achieve the provisions of Section M1, M2, M5, and M6 of the Settlement Agreement. At the time of the review, many of the specific action steps put forward in these sections, with the exception of M6, were "Not started." In addition, there were no specific action steps put forward to achieve the provisions of M3 and M4. According to the Chief Nurse Executive and Center Lead for Section M, at the time of the updated POI, the facility's self-rating indicated that it was in noncompliance with all provisions of Section M. The monitoring team was in agreement with these self-ratings.
	Summary of Monitor's Assessment: The Settlement Agreement required that SGSSLC ensured that individuals received nursing care consistent with current, generally accepted professional standards of care. During the conduct of the review, it was evident that since the prior review, many nurses continued to work hard. However, during observations and reviews of many documents, it was evident that the Nursing Department continued to struggle over how to meet the provisions of Section M, and were somewhat frustrated over taking one step forward and, sometimes, two steps backward. For example, a review of the department's own self-assessment data revealed some initial improvements, then a decline across several provisions of Section M, with documentation and assessment being two significant examples of where this had occurred. As noted during prior review, there was no doubt that the Nursing Department continued to be affected by high turnover and a high number of vacancies, with 17 vacant positions across all levels of the Nursing Department, which was 20% of the department's total workforce.

	Notwithstanding the struggles, over the past six months, the Nursing Department developed and implemented policies and procedures, enhanced and improved some existing systems, and invested considerable time and resources in improving the accountability and administration of medications and reduced medication errors and unexplained variances. However, the improvement and existence of policies, procedures, and processes in and of themselves were not sufficient to ensure that nursing care was delivered in accordance with standards of care and the provisions of the Settlement Agreement. During the onsite review and document review, there were some examples of some nurses who provided some aspects of nursing care consistent with standards of care, but there were many examples of nurses who did not. For example, there was evidence that nurses failed to conduct adequate and appropriate assessments of individuals with high risk conditions and observable and notable changes in their health status; nurses failed to administer medications in accordance with standards of practice, and as a result of one particularly egregious failure, it was necessary for the monitoring team to intervene in order to protect an individual from receiving six times more than the prescribed amount of medication. There were also a number of problems with the development and implementation of an adequate infection prevention and management program at the facility, as well as evidence that nurses violated basic standards of infection control during their delivery of nursing care. In addition, despite the presence of the QA nurse's thorough analyses of nursing care and comprehensive, clinically significant, prudent recommendations to improve care, there were a number of failures by the Nursing Department to implement recommendations at all and/or in a timely manner, and/or provide reasonable explanations for why recommendations were not carried out.

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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.	Since the prior review and SGSSLC's administrators' swift actions to address the nursing shortage, there continued to be vacancies, utilization of overtime, and almost daily use of nurses to "cover" homes. During the conduct of the review, the monitoring team observed first hand the oft apparent struggles and frustrations experienced by members of the Nursing Department who had seen their efforts to take steps forward affected by high turnover and high numbers of vacancies in the Nursing Department. A review of the Nursing Department's own self-assessment data revealed negatively changing trends in the measures of overall compliance across the audit tools completed for documentation and keeping appropriate records of individuals' health status. Without a doubt, these trends and problems were associated with the fact that there were 17 vacant positions across all levels of nursing staff, which was 20% of the Department's entire workforce. During the conduct of the monitoring review, eight homes were visited, 15 nurses were interviewed, and 20 individuals' records were reviewed. As noted in the prior review,	Noncompliance

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		the records were very well organized and maintained since the prior review. However, during the monitoring team's visits to the individuals' homes, it continued to be commonplace for the individuals' records to be "off the home" and not available or accessible to the physicians and/or nurses, who needed the records to ensure that accurate, pertinent health and medical information was available to the clinical professionals who needed the information in order to provide safe and necessary care/treatment to the individuals. This was observed to occur even after the purported "record curfew" of 5:00 pm. Since the prior review, SGSSLC's nurses were re-educated and re-trained on the facility's expectations for correct documentation of nurses' notes, and the Nurse Educator completed a competency-based training on SOAP charting. Improvement in the format of nurses' notes, which were mostly documented in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, was noted. However, as noted in the prior review, the content as well as signature/credentials appearing in some nurses' notes were not legible. Also, some nurses notes were unsigned and entries were obliterated without proper designation as an erroneous entry, and many nurses' notes continued to include uninformative, cryptic phrases that provided little, if any, specific, objective and/or subjective information to guide and direct planned interventions and/or caregivers' activities (e.g., "No difficulties noted," "Eating/drinking ok," "Did not appear to be in pain," "[Skin] does not look as moist looking as [it] has been," "Checks WNL). A rating of noncompliance was made for this provision because of the frequent and regular absence of complete nursing assessment and follow-up to individuals' emergent health care problems and needs and a pattern of failure to develop adequate, appropriate, individualized plans to address/resolve individuals' health problems, needs, and risks through the implementation of planned, individualized interventions. There was evidence across the 20 individuals reviewed that the individuals' direct care staff members had clearly benefitted from training and education provided by the Nurse Educator regarding "Observing and Reporting Clinical Indicators of Health Status Change." As a result, direct care staff members usually notified the individuals' nurses in a timely manner of significant changes in the individuals' health status and needs. Even minor changes in individuals' appearance and conduct usually prompted a report to the nurse on duty by the direct care staff member. However, once the nurses were notified, there was a significant pattern of failure by the nurses to ensure and/or conduct complete nursing assessments and provide timely and appropriate follow-up nursing care to the 20 sample individuals reviewed. Some of these failures appeared to be the result of lapses in continuity of care across shifts, between weekdays and weekends, and among the ranks of nursing staff members, such as lapses in communication between LVNs, RNs, and RN case managers.	

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		Numerous examples from this sample indicated the seriousness of this problem at SGSSLC and extended to all phases of the nursing process from assessment to evaluation of plan effectiveness. • Individual #22 was a 48-year-old man, who, from June 2011 to July 2011, suffered a 20-pound weight loss. On 7/26/11, Individual #22's weight loss prompted his RN case manager to notify his nurse practitioner who ordered several blood tests, fecal occult blood and h.pylori tests, meal and snack monitoring and recording of intake for one week, and daily weights with the same scale to rule out h.pylori infection, gastrointestinal bleeding, medication side effects, etc. Notwithstanding the significant change in Individual #22's health status and his nurse practitioner's orders for monitoring and recording changes in his health status, weeks and months went by before Individual #22's nurse practitioner's orders were fully implemented. For example, Individual #22's stool specimen was not obtained until two months later, and tracking and recording of his intake was not documented and forwarded to his dietician until four months after it was ordered. There were no explanations or justifications for these significant delays in care and treatment. • On 10/17/11, Individual #162's direct care staff member reported to her nurse that she was hit on the left side of her head and left ear with a rock by one of her peers. According to Individual #162's nurse's note, Individual #162's left ear was bruised and tender. The next day, Individual #162 complained of a migraine headache. Her nurse noted that she had a "soft raised mass" behind her left ear, obtained an incomplete set of vital signs, administered ibuprofen 400 mg, and planned to follow-up. There was no evidence of follow-up until almost 14 hours later when her nurse observed her holding her head and she continued to complain of a headache. Again, Individual #162's nurse administered Ibuprofen 400 mg, but failed to assess her ear injury and/or the signs/symptoms of possible head injury. Of note, there was no evidence that Individual #162's injury and change in health status was completely assessed and evaluated until over 72 hours post-injury when her RN case manager noted that he/she received a request for physical assessment for an "allegation of neglect due to being hit by a rock." On 10/21/11, four days after Individual #162's injury, her physician examined her ear, which was now draining and painful. At this time, Individual #162's physician noted that she had been "struck by a large rock on 10/17/11," and he/she referred Individual #162 to an ear/nose/throat (ENT) specialist. • On 7/11/11, Individual #81 fell backward down a flight of stairs. She was transferred to the emergency room for evaluation and discharged with a diagnosis of "concussion with loss of consciousness, pelvis contusion, and cervical/thoracic strain." Despite the emergency room physician's diagnosis and	

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		recommendations for aftercare, Individual #81's nurse noted, "No neuro check needed due to stable neuro check at this time [upon return from ER]." Clearly, Individual #81's nurse's opinion that neuro checks were unnecessary due to initial findings that were within normal limits was not based upon reasonable and prudent nursing judgment. In addition, the nurse failed to implement the state's and facility's policies for monitoring, assessing, and evaluating response to treatment for possible head, neck, back, and pelvic injuries. • Individual #339 was a 26-year-old man who, despite his relative youth, had significant health needs associated with hypertension, asthma, possible mild obstructive pulmonary disease, varicose veins, and cellulitis and non-healing right lower leg ulcer with abscess. Nonetheless, during the prolonged four-month period of time that he suffered from a non-healing right leg ulcer, which required treatment by the local hospital's wound care clinic, there were over 50 days without evidence of nursing oversight of his health needs and risks. Significant lapses in nursing oversight and monitoring of Individual #339's wound care occurred during periods when Individual #339 suffered complications such as infection, pain, and swelling of his lower extremities. In an effort to ensure better monitoring and more timely and consistent interventions, Individual #339's nurse practitioner ordered his nurses to "Please assure that [Individual #339] is wearing his compression stockings and visualize his legs for possible wounds when he complains of pain." Regarding numerous individuals • There were several good examples of opportunities for SGSSLC's nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered. One example was within the realm of their role and responsibility to ensure that Acute Care Nursing Assessments were completed on behalf of individuals going to/coming from emergency rooms, pre- and post-hospitalizations, and during stays in the facility's infirmary. Thirteen of the 20 individuals in the sample were sent to the emergency room, hospitalized, and/or stayed in the facility's infirmary. Not one of the 13 individuals' records contained fully completed Acute Care Nursing Assessments. Most assessments were partially completed, and others were not completed across multiple shifts for one or more days. • One other example of opportunities for SGSSLC's nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of the nurses' role and responsibility to ensure that staff members were adequately trained and appropriately responded to actual medical emergencies vis a vis mock medical emergency drills.	

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		o A review of the SGSSLC Emergency Response Drills for May 2011 through September 2011 revealed that of the 248 drills conducted, all drills passed the test. According to the drill reports, staff members who needed prompting were provided prompts and on-the-job refresher training to ensure that all drills were successfully completed. Notwithstanding these positive findings, there continued to be several areas that required improvement. o The monitoring team's onsite review of the 248 Emergency Drill Checklists revealed that nurses and direct care staff members were usually the only participants in the drills. On occasion, other staff members, such as QDDPs, habilitation staff members, and therapy technicians, also participated in the drills. However, there was no evidence that other staff members, who had direct contact with the individuals, such as physicians, psychologists, psychiatrists, and the specialty nurses, were included and/or responded to any of the 248 drills. o The review of the checklists also revealed a number of drills where the Drill Instructor noted that there was "no escort for EMS" to the scene. Upon follow-up by the monitoring team, it was reported that the most likely explanation for this finding was that there were probably not enough staff members on duty and/or participating in the drill to carry out this duty. This was an especially significant finding given that there was more than one floor, entrance, etc. to most units. o During the conduct of the drills, it was also noted that the Administration Building had "no CPR trained staff members in this area." It was noted by the Drill Instructor that the plan of action was, "See what procedures will be best for this area since there are no CPR trained staff members in this area. To be completed by 9/10/11." As of the review, there was no follow-up to this recommendation. Of note, there was no evidence in any of the nursing reports, meetings, minutes, etc. that indicated that the Nursing Department had identified and/or addressed the problems referenced above.	
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	According to this provision item of the Settlement Agreement, nurses are responsible to perform and document assessments that evaluate the individual's health status sufficient to identify all of the individual's health care problems, needs, and risks. The Settlement Agreement, as well as the DADS Nursing Services Policy and Procedures, affirmed that nursing staff would assess acute and chronic health problems and would complete comprehensive assessments upon admission, quarterly, annually, and as indicated by the individual's health status. Properly completed, the standardized comprehensive nursing	Noncompliance

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	indicated by the individual's health status.	assessment forms in use at SGSSLC would reference the collection, recording, and analysis of a complete set of health information that would lead to the identification of all actual and potential health problems, and to the formulation of a complete list of nursing diagnoses/problems for the individual. According to the facility's 11/22/11 POI, since the prior review, on a monthly basis, the results of the audits of nursing assessments for compliance with standards of care, provisions of the Settlement Agreement, and the state's and facility's policies revealed a steady decline in compliance from a high of 79% to the currently reported low of 60% compliance. Consistent with the facility's own self-assessment, a review of the 20 sample individuals' records revealed that the nursing assessments failed to provide one or more components of a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including, but not limited to, medications and treatments, to achieve desired health outcomes. In addition, current annual and/or quarterly nursing assessments were not present in 25% of the 20 records reviewed. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. As a result, a rating of noncompliance has been given to this provision item. The most commonly occurring problems in the nursing assessments appeared to be the result of nurses copying over prior assessments from one period to the next without accurately and completely evaluating and assessing the individual and his/her health status during period under review. Sometimes this problem was blatant, other times it was less obvious, but nonetheless resulted in portrayals of the individual and conclusions regarding his/her health status that were inaccurate and inconsistent with record notes, summaries, reports, consultations, etc. Thus, there were frequent observations of (1) incomplete lists of current, active medical conditions, (2) incomplete references to consultations and associated recommendations, (3) absent evaluations of the individuals' response to and effectiveness of their medications and treatments, (4) brief and uninformative notes of the results of the nurses' quarterly meal monitoring, (5) inaccurate history, function, psychosocial, and physical assessments with little to no explanation of negative findings, (6) reiterations of the same summary information from one quarterly assessment to the next without editing and inserting adequate, appropriate, and accurate contemporaneous information, and 6) deficient identification of nursing problems and diagnoses.	

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		Examples of these findings are presented below. • Individual #288 was a 62-year-old man who suffered two hospitalizations during the brief two-week period of 8/29/11 – 9/12/11. First, Individual #288 was hospitalized for treatment of a twisted colon and underwent surgery for colon resection and colostomy and, second, he was hospitalized for treatment of pneumonia. Notwithstanding the significant changes in Individual #288's health status, functioning, and needs, his nurses failed to complete a head-to-toe comprehensive nursing assessment. Although a comprehensive nursing assessment was not scheduled to occur until December 2011 for the period of 8/11 – 11/11, the state's and facility's policies regarding nursing assessments clearly required assessments "to be completed as indicated" by significant changes in the individual's health. Two hospitalizations in two weeks, surgery, new colostomy, and post-operative recovery were indeed significant changes in Individual #288's health status and functioning. • Individual #151 was a 30-year-old man who was notably "healthy" and "physically active," according to his physician. However, during Individual #288's annual physical examination, his physician cautioned that his "blood pressure bears watching." Despite this cautionary note, there were no references to "watching" Individual #151's blood pressure in his nursing assessments and no references to this actual/potential health risk in his list of nursing problems/diagnoses. This was especially significant since during Individual #151's nurses' conduct of their quarterly nursing assessments, his nurses obtained and recorded elevated blood pressure and pulse measurements. • Individual #189 was a 62-year-old man with many health needs and risks that included diabetes mellitus, hypertension, renal insufficiency, chronic leukopenia, anemia, thrombocytopenia, GERD, asthma, chronic sinusitis, vision impairment, and gingivitis. In addition, during the period immediately preceding his quarterly comprehensive nursing assessment, he was hospitalized for treatment of uncontrolled diabetes mellitus with symptomatic hypoglycemia, metabolic encephalopathy, acute renal failure, and anemia. Notwithstanding Individual #189's many health needs and risks, his nursing assessment listed no nursing problems/diagnoses and no nursing summary of the quarterly period. Thus, it was unclear how his HMPs would or could be developed, reviewed, and revised absent the derived problems and conclusions that should have been formulated from his assessment. • Individual #22 was a 48-year-old man who was a smoker that suffered from chronic obstructive pulmonary disease and other chronic conditions, including hypothyroidism and a large paratracheal mass that covered and put pressure upon his nerves causing pain. Over the past several months, Individual #22 also	

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		suffered a significant unplanned 20-pound weight loss. Of note, Individual #22's comprehensive nursing assessments' sections regarding his respiratory, endocrine, and smoking history and status were blank. In addition, there was no specific data analysis or evaluation of his weight loss, save for the cryptic phrase, "Weight is low, but has stabilized." <u>Regarding Numerous Individuals</u> • Of the 20 sample individuals reviewed, almost half of the individuals' nursing assessments revealed that it was their nurses' professional opinion that they could not be served in a less restrictive setting. Although the nursing assessments instructed the "discipline representative" to provide further documentation of the reasons why the individual could not be served in a less restrictive setting, there were almost no reasons put forward and no evidence of the basis for the nurses' opinion, save for the redundant explanation that the individuals need not be served in a more integrated setting because they were served in the least restrictive setting. • Of the 20 sample individuals reviewed, at least four allegedly engaged in sexual contacts, reportedly without protection from sexually transmitted diseases, with more than one partner. The IPNs of all four individuals indicated that, upon initial reports of alleged sexual contact, their nurses attempted to conduct a complete nursing assessment. However, subsequent to the individuals' initial refusals, there were no other documented attempts by their nurses to conduct complete assessments and/or provide the individuals with health education/information. Of note, the majority of the nurses' initial assessments noted that they were unable to complete assessments of the individuals' "lower torso," "peri-area," etc. It did not appear that anything, had occurred to finalize the draft policy of "Assessment after Allegation of Sexual Incident," which was drafted to guide and direct nurses' conduct during these situations and presented to the monitoring team during the prior review. • Of the 20 sample individuals reviewed, as a result of acute changes in their health, such as fractures, deep lacerations and puncture wounds, injuries, surgical procedures, ulcers, etc., eight of the individuals required ongoing pain assessment and monitoring. Strikingly, despite the documented presence of subjective complaints of pain and physicians' orders for opioid analgesics, there were next to no pain assessments filed in these individuals' records and frequent failure to conduct post-medication monitoring and assessment of individuals' response to the administrations of as-needed (PRN) pain medication(s).	

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M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	The Health Care Guidelines and DADS Nursing Services Policy and Procedures clearly called for written nursing care plans, which were based upon the nursing assessments, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times, to be developed for all individuals. The nursing interventions put forward in the individuals' plans were required to reference specific, personalized activities and strategies designed to achieve the individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of the interventions. During the prior review, it was noted that individuals' health management plans were in different forms/ formats and varying states of completion. Almost none were reviewed at least quarterly, appropriately individualized, revised when the individuals' status and needs significantly changed, signed by the appropriate staff members (nurse and ATP), and properly dated with dates of implementation, review, and, when applicable, revision and/or resolution. The 11/22/11 POI referenced that there were only two activities undertaken by SGSSLC to improve compliance with this provision item. One activity was that the physicians revised their Consultation Process policy to require that the physicians write an order for RN case managers to communicate with and/or provide health information to the individuals' PSTs, and the other activity undertaken was that RN case managers were trained on this policy revision. No other action steps were planned or completed in an effort to improve compliance with this provision item. Thus, it was not surprising that the current review revealed that although all 20 sample individuals had one or more HMPs and a few individuals had one or more ACPs filed in their records, there was little to no progress made in improving the presence, nature, and quality of individuals care plans. As a result, a rating of noncompliance was given to this provision item. Some general comments regarding the 20 sample individuals' care plans are below. • During informal interviews with individuals direct care staff members, it was reported that the plans most frequently reviewed and followed were the Physical Nutritional Management Plans (PNMPs), not the HMPs or ACPs. The reason most often put forward to explain this finding was that the PNMPs were "kept up," "helpful," "guide us when we take care of [individual]," and "usually always [accessible] in the training book." • In 20 of the 20 individuals reviewed, the HMPs did not consistently address all of the health care needs of the individuals, and ACPs were prepared for only six of the 20 individuals in response to individuals' acute and/ or emergent health care needs and risks. • All of the 20 individuals reviewed had one or more stock care plans, which when	Noncompliance

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		assembled together were considered to be the individuals' HMPs. However, almost none of the stock care plans had been adequately customized and/or personalized to address individuals' specific health problems and risks. And, not one related to the other. Rather, these stand alone plans referenced generic interventions mostly related to "monitoring" and "reporting" activities and usually instructed the reader to follow other plans and/or do "as ordered." • For most individuals, the stock care plans were inappropriate and inadequate to meet their health needs. For example, the stock care plans that addressed chronic problems such as "Constipation" and "Weight Management" referenced the same health goals and interventions regardless of the severity of the problems, the individuals' co-morbid conditions, the individuals' ability to understand and participate in the interventions, etc. Thus, the intervention to "Err on the side of waiting for nature," and the adage of, "Waiting one more day will do no harm" were inappropriate and potentially harmful strategies that were put forward to address the chronic constipation of Individual #217 who had multiple co-morbid conditions and a limited ability to communicate. Of note, although Individual #217 recently suffered complications of her chronic constipation and required emergency medical treatment and hospitalization to address a possible bowel obstruction, the stock constipation care plan was not revised. • Most of the sample individuals who were usually prescribed at least two psychotropic medications failed to have HMPs that referenced nursing and direct care staff members' interventions to monitor side effects. • Despite changes in individuals' health status, progress or lack of progress toward achieving their objectives and expected outcomes, and RN case managers' quarterly reviews of HMPs that were not producing desired results, the HMPs were not revised, and they did not reflect the individuals' most current conditions and intervention strategies. • ACPs, when developed, were not signed/dated upon resolution of the acute health problem. • Goals of many of the plans were not specific, measurable, attainable, and/or relevant to the individuals. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #294 was a 64-year-old man who, over the past few months, fell at least nine times, hit his head and face at least four times, and was frequently found with multiple bruises. Notwithstanding his physician's concern, frequent injuries, and failure to make progress toward meeting his health goals, there were no revisions made to his 5/11/11 HMP related to falls and potential for injury. In and of itself this was indicative of a failure to implement Individual	

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		#294's HMP, which specified that his caregivers must promptly respond to the degeneration of skills, especially when the degeneration led to risk of injury and/or evidence of actual injury. • Individual #189 was a 62-year-old man diagnosed with diabetes mellitus, hypertension, renal insufficiency, chronic leukopenia, anemia, thrombocytopenia, GERD, vision impairment, chronic sinusitis, asthma, alteration in skin integrity, and gingivitis. Notwithstanding his many health problems and needs, as of the review, he had only two HMPs filed in his record – one developed on 5/10/11 to address the possible side effects of one of his medications, and one developed on 8/31/11 to address his diabetes mellitus. • Individual #78 was a 53-year-old man diagnosed with many chronic health problems, most of which were not addressed with HMPs. For example, as of the review, Individual #78 failed to have HMPs to address his Prader-Willi Syndrome, hypertension, hypothyroidism, severe obstructive sleep apnea, spinal stenosis of his cervical vertebrae, osteoarthritis, vitamin D deficiency, constipation, dysphagia, seborrhea of his scalp and face, hyponatremia, diabetic retinopathy, and poor oral hygiene. • Since the prior review, Individual #288 suffered abdominal pain secondary to descending colon torsion, underwent surgery, and had a colon resection and new colostomy. Nonetheless, his HMP related to constipation, which was filed in his record, was not revised to reflect the significant changes in his bowel status and functioning and continued to reference interventions that were not to be implemented as directed. o Also, his HMP related to his colostomy and colostomy care was confusing. For example, the plan directed Individual #288's direct care staff member to "gather [a] nurse's cap," "empty the contents [of the colostomy pouch] into the nurse's cap," and "empty the contents from the nurse's cap and rinse." It was unclear what was meant by "nurse's cap," why the contents of Individual #288's colostomy were not to be emptied into the toilet, and what was specifically expected of Individual #288's direct care staff members to ensure that he was kept clean and comfortable. Thus, it was not surprising that Individual #288 was found with "strong odor of feces as soon as [caregiver] entered room…there was dry feces on [Individual #288's] stomach, upper thighs, hands, and forearms [and] fresh feces on the left side of his abdomen…" Despite this untoward incident and proposed "plan" for Individual #288's RN case manager to complete an acute care plan that would guide and direct his direct care staff members, as of the review, there was no clear, specific, individualized plan developed for Individual #288 and his direct care staff members to follow.	

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M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	According to the 11/22/11 POI, since the prior monitoring review, there were "No initiatives started" and no action steps put forward to help the facility move toward meeting this provision item of the Settlement Agreement. As noted above, there continued to be numerous problems in the implementation of the nursing assessment and reporting protocols specifically developed by the state, and some developed by the facility, to improve nursing practice and ensure consistent application of the nursing process from assessment, to diagnosis, to plan development, to implementation of interventions, and to evaluation of outcomes. According to the Nursing Operations Office (NOO), who was also acting on behalf of the Chief Nurse Executive (CNE), the biggest issue that continued to affect the Nursing Department was "staffing." There was no doubt that a number of nurses continued to work hard, but their struggle over how to meet the provisions of section M with continued high turnover and 20% vacant positions in the Nursing Department was evident. There were some activities undertaken by the Nursing Department to review and analyze the status of nursing staff deployment at SGSSLC. For example, unscheduled absence was identified as a serious problem, new concepts for policies and procedures such as "On Call," "Hold Over Schedule," and "New Attendance" policies were discussed, vacancies were posted, job descriptions for some nursing positions were requested, and a CNE review of current staffing on specific units was requested. Unfortunately, after weeks of review and discussion, there were no results from these activities. Notwithstanding the department's struggle over how to best utilize and deploy their nursing staff, there was evidence that over the past six months the Nursing Department had indeed taken some steps to develop and implement nursing assessment and reporting protocols. For example, the nursing management began holding a weekly "Hot Spots" meeting, where the nursing management team discussed staffing problems, reviewed the role and responsibilities of nurses across various processes and protocols, drafted revised policies and procedures, discussed the outcomes of the PITs (performance improvement teams) initiatives and recommendations, and strategized over how to improve the delivery of nursing supports and services across the facility with the resources available to them. Notwithstanding the regular meetings of nursing management to keep on top of the pressing issues and problems of the day, during the monitoring team's informal interviews with several nurses, they reported differing opinions on the presence and nature of possible barriers to achievement of compliance with the provisions of the Settlement Agreement and Health Care Guidelines. According to some of the nurses who were interviewed, the expectations of the provisions of Section M were "attainable goals" that were "reachable" only if/when nurses were held accountable, disciplined, and	Noncompliance

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		worked together as a team. Other nurses reported that morale issues continued to loom large, and that "no nurse should ask another nurse to do a job that he/she would not or could not do." Thus, interviews with nurses continued to raised question over whether or not nursing leadership and management had completely addressed and resolved the work force issues noted during the prior review, which presented serious and persistent barriers to much needed improvements in nursing care. As of the review, the Nurse Educator had been in her position for three months, the Hospital Liaison has been in her position for two months, the Nurse Recruiter, had been recently hired, and the Infection Control Nurse had been in her position for one year. During the prior review, it was reported that the Infection Control Nurse was not being adequately supported from both within and outside the Department of Nursing. This remained unchanged. During the monitoring team's review of the presentation book and interview with the Infection Control Nurse, it was clear that she has not been provided with the tools she needed to do her job. The Infection Control Nurse continued to need additional training. She candidly reported that she could not do a reasonably adequate job without information, from both outside and inside the facility. For example, she requested to attend the infection control seminar, which was scheduled to occur later in the Spring in Corpus Christi, but, as of the review, her request was not approved. She drafted a revised policy that clarified the expectations for follow-up with individuals with infections including the responsibilities for reporting infections to the Infection Control Nurse, but, as of the review, she had not received comments from all of the nurses who were assigned to review the policy. Thus, it was not surprising that although the Infection Control Nurse was "doing more monitoring [than before]," doing more training during NEO, and working on revising outdated facility policies and procedures, there continued to be a number of elements of the job requirements of the Infection Control Nurse that were planned, but not fully carried out. For example, one of the most important duties of the Infection Control Nurse was implementing a formal process that ensured that infectious and communicable diseases were reported accurately, completely, and timely, including all individuals who had either a chronic or acute infectious or communicable disease processes. During the conduct of the review, the monitoring team discovered at least one example of an infectious and highly contagious disease that was not reported to the Infection Control Nurse. In addition to the apparent lack of structure and processes in place to identify and address actual and potential infections and reduce the likelihood of contagion and outbreaks of infection(s), there continued to be no training curricula developed for specific high risk infections, which were associated with residential facilities like SGSSLC. Also, there was very little monitoring and oversight of the implementation of infection	

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		control processes and procedures at the facility. For example, as of the review, there were only six observations of six employees' implementation of proper hand washing conducted during the six-month period of 6/11-11/11. The Infection Control nurse reported that once a month, infection control observations were made on the units. A review of the reports of these observations revealed that during the six-month period of 6/11-11/11, a total of 14 Infection Control Observations Reports were completed. These reports identified many problems with improper food storage, urine odors, dirty/soiled clothes hampers overflowing and uncovered, clean clothing stored on the floors, furnishing covered with dust, etc. Notwithstanding the persistent pattern of problems identified across the 14 reports, there was no evidence of follow-up to the findings of these reviews, which were reportedly communicated either face-to-face or via email to home managers and/or housekeeping. A review of the Infection Control Meeting Minutes revealed that, although there were a number of serious problems identified, such as concerns regarding tuberculosis infection, and significant increases in fungal and urinary tract infections, adequate assessment and reporting processes failed to occur. As noted during the prior review, the only recommendation put forward to address these serious problems were limited to "Continue Monitoring." Given the repeated failure of SGSSLC to address significant patterns and trends in infection control and management, the serious problem of failing to adequately protect individuals' health and safety risks associated with needless exposure to infections had persisted. At the time of the review, the Nurse Educator had been on the job only three months. Over the past three months, she conducted some training sessions on SOAP documentation during nursing meetings, provided one-on-one training on medication administration to several nurses who were referred to her by the NOO, developed the curriculum and conducted training on seizure management for new employees, and began making preparations for the nurses' annual competency training and evaluation sessions, which was scheduled to occur in May 2012. According to the Nurse Educator, the dates of the physical assessment training course sessions were not scheduled, and it remained unclear whether or not the specialty RNs, including the QA Nurse, PNMT Nurse, and Clinic Nurse, would be included in the training program. Since the prior review, the Nurse Educator reported that a presentation book, similar to what was provided to the monitoring team during the prior review, was no longer required. The Nurse Educator, however, maintained a database of information that captured the date(s) when education and training were provided to each and every nurse at the facility. A review of the database revealed that it did not track nurses who were	

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		delinquent in completing their training, education, and competency evaluation requirements. Thus, contrary to the former Nurse Educator's database, there were no lists of nurses who missed one or more of the Nurse Educator's training/education sessions and no data that revealed which nurses missed the structured training/education sessions, and, as a result, submitted only written verification that they participated in "informal training." The monitoring team reviewed a random sample of nurses' training and education records. It was accepted practice for portions of the nurses' training to be conducted while on-the-job. Although the Nurse Educator usually received some type of "verification" that the nurses successfully completed and demonstrated competence in the areas reviewed while on-the-job, there was at least one nurse where several months had passed since the nurse's date of hire, yet there were several blank entries for on-the-job training. The Hospital Liaison, who had been on the job only three days, had picked up where the former Hospital Liaison left off. However, during the several months preceding her hire, the CNE assumed these duties. According to a review of the 20 sample individuals' records, nine of the 20 individuals were hospitalized one or more times during the six-month period preceding the review. There was evidence that less than half of these individuals were regularly visited by the CNE. The Hospital Liaison Reports, which were filed in the individuals' records, referenced brief assessments of the status of the individuals' systems, such as their skin, neurological, cardiovascular, respiratory and gastrointestinal systems, noted completed labs and tests, and listed prescribed medications. The reports, did not, however, provide even brief analyses and/or summaries of the meaning and relevance of the assessment information and its impact on the individuals' progress/lack of progress during their hospitalization. Also, the dates of the individuals' discharges were "unknown" right up until the day they were discharged. And, there was little to no information in the reports to assist with planning the individuals' re-admissions to SGSSLC and ensuring the continuity of their care. The newly hired Hospital Liaison appeared to be very knowledgeable of applicable standards and hospital procedures and protocols. She embraced the autonomy of her new position and took it upon herself to establish communication and collaboration with home managers, unit managers, and other nurses. Similar to the former Hospital Liaison, she reported her commitment to advocate on behalf of the individuals' needs for safety and proactive treatment to protect them from harm during their hospitalizations. As reported in all prior monitoring reviews, the QA Nurse continued to play a vital role in the facility's efforts to meet the provisions of the Settlement Agreement. Since the prior review, the she conducted a number of monitoring reviews of the quality of nursing care	

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		and completed comprehensive, critical yet thoughtful reviews of the delivery of nursing supports and services. For example, The QA Nurse completed reviews of nurses' mealtime monitoring reports, the compendium of monitoring tools related to nursing care, and focused investigative reports of the enteral feeding and medication variance. Each and every review conducted by the QA Nurse culminated with recommendations to improve the delivery of nursing care. However, there was no evidence that many of these recommendations were implemented, and some of the recommendations that were implemented took several weeks, if not several months, to carry out. For example, a review of the QA Nurse's reports and recommendations regarding enteral feedings and medication variance revealed that less than half of the recommendations put forward in these reports were implemented. The reason for this finding was not evident during the conduct of the review or explained by a review of the numerous documents, reports, and records received. A review of the results of the ongoing measurement of the inter-rater reliability revealed that the inter-rater scores related to the monitoring of nursing care fell below 80% for the first time. According to the QA Nurse, the QA and Nursing Departments met to review the results and found that there were some problems with the assignment of "No" versus "N/A," but these problems were quickly and relatively easily resolved. This was an improvement from the prior review, which found widely varying measures of reliability across reviewers and no evidence of plans to address these significant findings. The QA Nurse also reported on the various performance improvement team activities, which were underway at the facility. The "PITs," which stood for Performance Improvement Teams, were the facility's designated oversight and monitoring teams developed in response to problems and performance issues identified vis a vis the monitoring reviews and other reports. For example, since the prior monitoring review, two additional PITs were developed to address the problems and performance issues that were revealed during the conduct of the QA Nurse's reviews – the Pneumonia PIT and the Enteral Nutrition PIT. A review of the Pneumonia PIT reports and updates revealed that there were some meeting minutes with dates, agendas, and recommendations for current/future actions. However, there were also a number of "PIT updates" without dates, agendas, and clearly discernable plan of action to meet the goal of "two months at the most to get the processes in place." (See Section M6 for the review of the Enteral Nutrition PIT) One of the most striking comments made by the QA Nurse was when she unassumingly said that she was "on the homes, a lot." That is, while "on the homes" doing what the QA Nurse does, she made it part of her job to share findings, ideas, concerns, and praise with	

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		unit nurses and managers. It was said best by the QA Nurse when she offered, "You physically have to be there on the homes to offer an informed opinion…It's a reality check." At the time of the review, the Nurse Recruiter position was filled. However, since the nurse was hired for this position, she has been out on leave. Thus, many of the proposed plans for recruitment were on hold. At the time of the review, the Nursing Department's vacancies increased from six vacant positions, which was noted during the prior review, to 17 vacant positions. This was a significant finding because the current number of vacancies was almost as high as the critically low point of 19 vacant positions, which was noted during the November 2010 monitoring review.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The purpose of a well functioning risk assessment and planning process was that it may prevent the preventable. At the time of the monitoring review, SGSSLC was almost through its first year of implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process. According to the facility's 11/22/11 POI, individuals' annual nursing care plans were specifically audited to ensure that potential and actual health risks were identified and addressed. The facility's monthly audits revealed compliance scores that had significantly improved from a low of 82% to a current high of 95% compliance. Also, since the prior review, the POI indicated that the Nurse Educator began using the state's approved curriculum, which included a section on care plan development, during new nurse orientation as a step toward achievement of compliance with this provision item. Ensuring that risks were identified and addressed vis a vis care plans was a positive step in the process. However, it was not sufficient to achieve positive outcomes, which required consistent implementation of individualized interventions designed to thwart, not correct after the fact, untoward health events. One of the most obvious steps taken by the Nursing Department to participate in the development and implementation of a system of assessing and documenting individuals' indicators of risk was the attendance and participation of the individual's nurse in the PST process. During the conduct of the review, the monitoring team attended one PSPA meeting, which was held as a result of significant changes in individuals' health needs and risks. The individual's nurse practitioner clearly took the lead during the meeting and ensured that language barrier and other obstacles to including the individual's LAR (mother) and immediate family member (sister) in the process were identified, addressed, and resolved. Thus, at the time of the meeting, all members of the individual's PST, except his physician, were present either physically or via conference call. During the conduct of the PSPA and risk review, it became evident that no one, including the individual's RN case manager, had notified the individual's LAR of his hospitalization	Noncompliance

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		for treatment of complications of constipation. In addition, it was revealed that neither the RN case manager nor the other members of the team were aware of the individual's significant history of problems with constipation and frequent urination during his home visits; and no one was knowledgeable of the course of his hospitalization or aware that he had been discharged and on his way to the facility. By the end of the meeting, the individual's nurse practitioner had developed a plan to further examine the individual's multiple, complex, and inter-related health needs and risks. In addition, by the end of the meeting, the habilitation department's director, who was present at the meeting, also had developed a plan to further examine the individual's eating, swallowing, choking, and aspiration risks. It was unclear, however, what, if any health management plans would be developed by the individual's RN case manager to address his unfolding health needs and risks. This was especially significant because it was not apparent during the conduct of the meeting that his nurse was cognizant of the complexity and gravity of his health risks. All 20 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and over half of the 20 individuals reviewed were referred to as having one or more "high" health risks. Since 1/1/11, all of the 20 sample individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. Although there were significant improvements noted in the assignment and re-assignment of health risk ratings, there continued to be evidence of a number of problems with RN case managers, who failed to demonstrate that they consistently identified and raised health risk problems in a timely way such that the likelihood of negative health outcomes was reduced, availed themselves of all accessible pertinent health information and data, fully prepared prior to the PST meetings, formed educated opinions, and served as the individual's "health advocate" during the PSPA process. Therefore, this provision item was rated as noncompliance. Examples included the following: • A young woman was recently re-admitted to SGSSLC from the Shannon Behavioral Unit where she was being treated since her precipitous discharge from her group home placement. Subsequent to her return to SGSSLC, on 11/22/11, she was diagnosed with genital herpes. At the time of the review, her record revealed that she was receiving treatment for the viral infection. However, it was concerning that the Infection Control Nurse had not been informed that an individual was diagnosed with an incurable, highly infectious, extremely contagious, and easily transmitted disease, and the associated health risks to the individual and others had not been straightforwardly addressed. • Individual #278 was a 30-year-old medically fragile man with many health	

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		problems. In addition, Individual #278, who has a history of aspiration and aspiration related illnesses, was recently discharged fro the hospital for treatment of sepsis secondary to pneumonia. Also, Individual #278 was designated as having high health risks related to respiratory problems and osteoporosis. At the time of the monitoring team's observations on Individual #278's home, the attention of the monitoring team was drawn to Individual #278, who was sitting in his wheelchair in the presence of two RN case managers, because his face was beet red. According to the RN case managers, they had just conducted an "assessment" of Individual #278 and found nothing unusual. When the monitoring team probed further, the RN case managers reported that Individual #278 was assessed, and he did not have an elevated temperature. However, it was immediately ascertained that the RN case managers had not obtained a full set of vital signs, including one of the more obvious measures commonly associated with changes in vascularity - his blood pressure. In follow-up to the monitoring team member's repeated questions and prompts, Individual #278's blood pressure, which was significantly elevated and measured 159/104, was obtained. o It was a serious concern that, in the face of a significant change in Individual #278's health status, his nurses' "assessment" would be perfunctorily performed and without evidence that a complete and thoughtful review of all health risks and relevant and accessible current health information/data would be conducted in order to help ensure that the most complete information possible would be obtained and communicated to the individual's physician in a timely manner. • Individual #217 was a 61-year-old woman with many health problems, which included a significant history of chronic constipation and infection, respiratory and otherwise. Notwithstanding her multiple problems and risks, as well as her physician's recommendation for "constant monitoring" of her constipation, the potential health risks related to constipation and urinary tract infection remained low until she suffered the untoward health outcomes of impaction, small bowel ileus and possible bowel obstruction, and urinary tract infections. Subsequent to her hospitalization for these negative health events, her risk levels were changed to high.	
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	The administration of medication and the management of the medication administration system at SGSSLC had substantially improved since the prior monitoring review. As indicated in more detail below, at the time of the review, although much had been done, much was still underway to ensure that medications were more accountably stored and administered, in accordance with standards of practice and the Health Care Guidelines. Pending follow-up review for continued improvement in meeting the expectations of this	Noncompliance

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	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.	provision, this provision item was rated as being in noncompliance. According to the 11/22/11 POI, since the prior review, SGSSLC consulted with other state facilities regarding their procedures for medication administration and accountability, provided training to nursing staff members regarding expectations for counting and reconciling medications on a daily basis, developed a revised Medication Overage and Shortage form, implemented a system of counting and reconciling medications daily and upon delivery, and continued the Medication Variance Performance Improvement Team's oversight of these improvements. In the words of the Nurse Operations Officer, "Now we're getting accurate reporting of true medication errors, not 'dropped on the floor' medication errors." During the monitoring review, the monitoring team attended the Medication Variance Performance Improvement Team's weekly meeting. According to the Chairperson, counts of medications were occurring as scheduled and some revisions to the form/format of count sheets were being revised to make them user-friendlier. According to the Pharmacist, there were no medications being returned to or requested from the pharmacy without proper documentation of reconciliation and/or explanation for the over/short medication(s). Although there were indeed medication errors reported for the prior month (October 2011), the pharmacist reported that the errors had not adversely affected the individuals, and the errors were significantly less than prior months. Notwithstanding the positive findings, the onsite review of medication administration continued to reveal problems with administration of medications by nurses on the units. During the review, medication administration observations were conducted on 504A, 504B, 509B, 510A, 510B, 511A, 511B, and 516W. Observation of medication passes continued to reveal problems with nurses' compliance with standards of practice and the Health Care Guidelines. • During one of the eight medication passes observed, standard infection control procedures were not followed. • During one of the eight medication passes observed, it was necessary for the monitoring team member to intervene to protect the individual from receiving six times more than the prescribed amount of medication. The possible implications of over-dosage were bloating, cramping, gas, pain, diarrhea, vomiting, dehydration, fluid/electrolyte imbalance, and seizure. Although all of these are negative outcomes, they are especially dangerous and pose additional risks for the individual, who was medically fragile and diagnosed with multiple health problems, and was identified as having high risks in several of the state's	

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		list of health risks, including aspiration and aspiration-related illnesses. • During two of the eight medication passes observed, nurses had set up medications to be administered one to several hours later and failed to re-check the individuals' Medication Administration Records prior to administering these medications to the individuals. • During three of the eight medication passes observed, nurses documented the individuals' receipt of medications on the Medication Administration Records (MARs) prior to administration. • During one of the eight medication passes, liquid- and pill-form medications were pre-poured together into unlabeled medication cups, set on a shelf in the medication room, and administered by the nurse well over an hour later. o Although there were apparently physician's non-pharmacological orders that permitted nurses to "…crush, pour, and prepare medications up to two hours prior to administration to allow for proper dissolution in mixture," there did not appear to have been adequate follow-up by the nurses with the pharmacist to ascertain that there were no problems with pre-pouring and mixing 10 or more crushed medications along with Mylanta, guaifenesin, and liquid multivitamin altogether in a plastic cup and allowing the mixture to sit for over an hour before administration. • During one of the eight medication passes, when the nurse administered medications via enteral tubes, the nurse pushed the medications into the individuals' stomachs via syringe versus allowing the medications to flow by gravity with slight assistance by the syringe and only when/if needed. All of the 20 individuals reviewed had a SAM (self-administration of medication) assessment and designation filed in their record. During the observations of medication administration, most individuals were treated with respect, and the majority of individuals who had abilities to participate more versus the individuals who had abilities to participate less in the self-administration of medications were encouraged and supported to do so. The review of 20 individuals' current MARs for the period of 10/1/11 to 12/9/11 revealed that there were omissions and/or discrepancies in the MARs of 15 of the 20 individuals reviewed. These omissions and discrepancies included multiple missing entries for psychotropic, bowel, hypertension, seizure, hypoglycemic, allergy, and antibiotic medication(s), vitamins/supplements, and wound and skin treatments during the five-week period. There were also a number of individuals' MARs where medications, such as birth control medications, antibiotics, etc., were circled, but without explanation for why the medication(s) were possibly not given and/or refused. Although	

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		there were significant ramifications for missing and/or refusing medications, there was no evidence that this problem was identified or addressed during the medication audits and reconciliation processes. During the monitoring team's prior review of individuals' MARs, it was identified and reported to the facility's CNE and NOO that two individuals had not received their enteral nutrition and fluids, in accordance with their physician's orders. This report prompted a closer review of this problem and investigation by the QA Nurse, who found that there were indeed "errors consistently noted with enteral feedings" and "bizarre nature" of documentation of nutrition and fluids delivered via gastrostomy tube. These findings and more prompted the QA Nurse to complete a comprehensive report and resulted in eight prudent recommendations to the Nursing Department, all of which were to be completed either "ASAP" or by "August 31, 2011." • As of the review, it was disturbing to find that, in response to this serious problem, the Nursing Department had implemented only five of the eight of the recommendations, albeit several weeks to several months past due. The other three recommendations were not implemented as of the preparation of this report.	

Recommendations:

1. Ensure regular, non-punitive, supportive, predictable, physical presence of nursing leadership and management on the homes (M1-M6).

2. Complete the staffing development analyses and policies, and implement some corrective actions. (M1-M6).

3. Bring administrative and clinical supports to bear on the infection control and management processes to develop a program of infection prevention and management (M4, M5).

4. A focused effort on improving nursing practice during medication administration on the homes, including proper sanitary conditions, observance of infection control, and practice meeting basic standards of care. Note: Consider unannounced observations of medication administration if that is not already part of the monitoring (M6).

5. Review with the Medical and Pharmacy Departments the presence of non-pharmacologic orders that permit crushing, mixing, and pre-pouring multiple liquid and pill/capsule form medications for up to two hours prior to administration (M6).

6. Maintain the current system of accountability of medication administration to continue to substantially reduce errors, reduce requests for additional medications from the pharmacy due to unexplained shortages in medications, and minimize the return of un-reconciled medications to the pharmacy (M6).

7. Recommendations put forward during the focused reviews of enteral feedings and medication variance should be fully implemented, and if there are recommendations that are not going to be implemented, an explanation for why not should be provided (M4 – M6).

8. Nurse case managers should ensure complete information to the individual's PST during the PSP and PSPA processes, including, but not limited to, relevant and complete information to inform risk assessment and planning process, findings of the nursing assessment, individual's response to planned interventions, and progress/lack of progress made toward desired health outcomes (M5).

9. Address the frequent and regular absence of complete nursing assessment and follow-up to individuals' emergent health care problems and needs and a pattern of failure to develop adequate, appropriate, individualized plans to address/resolve individuals' health problems, needs, and risks by ensuring the timely development and implementation of planned, individualized interventions (M1 – M5).

10. The HMPs/stock care plans need to be individualized with interventions, timeframes, goals and desired health outcomes and developed with evidence of the individual's participation (M3).

11. Records must be available and/or accessible to the physicians and/or nurses, who need the records to ensure that accurate, pertinent health and medical information was available to the clinical professionals who needed the information in order to provide safe and necessary care/treatment to the individuals (M1 – M6).

12. Documentation expectations, particularly the SOAP charting as specified in the Health Care Guidelines, needs to be reinforced and monitored until nurses are implementing the process more systematically (M1-M6).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.1: Medical Care, 2/16/11 o SGSSLC POI for Section N o SGSSLC Organizational Charts o SGSSLC Pharmacists Prospective review Of Medication Orders, 11/17/11 o SGSSLC "PRN" Medication Pharmacy Review, 11/17/11 o SGSSLC Medication Variances, 11/3/11 o SGSSLC Quarterly Drug Regimen Review, 11/17/11 o SGSSLC Chemical Restraint Pharmacy Review Date o DISCUS - Monitoring of Medication Side Effects and Tardive Dyskinesia, 9/22/11 o MOSES – Monitoring of Side Effects 4/26/11 o SGSSLC Suspected Adverse Drug Reactions 1/27/11, Rev 11/17/11 o SGSSLC Pharmacy and Therapeutics Committee Corrective Action Process o SGSSLC Drug Utilization Evaluation 11/17/11 o SGSSLC Lab Matrix, 9/15/11 o Pharmacy and Therapeutics Committee Meeting Minutes, 9/26/11, 3/30/11 o Medication Review Committee Meeting Notes, 4/12/11, 7/14/11 o Medication Variance PIT Meeting Minutes: 6/24/11, 8/25/11, 9/15/11, 10/27/11 o Single Patient Interventions and Notes Extracts o Adverse Drug Reactions Reports o Quarterly Drug Regimen Reviews for the following individuals: • Individual #76, Individual #322, Individual #126, Individual #95, Individual #274 Individual #40 Individual #9, Individual #381, Individual #349, Individual #7, Individual #144, Individual #345, Individual #127, Individual #243, Individual #337, Individual #283, Individual #38, Individual #215, Individual #16, Individual #210, Individual #388 Individual #129, Individual #18, Individual #386 Individual #328, Individual #317, Individual #154 Individual #69, Individual #27, Individual #313, Individual #295, Individual #311, Individual #124, Individual #151, Individual #237, Individual #291, Individual #241, Individual #120, Individual #201 Individual #168, Individual #380, Individual #94, Individual #233, Individual #353, Individual #183 Individual #229, Individual #293, Individual #178, Individual #287, Individual #19, Individual #39, Individual #266, Individual #188, Individual #61 Individual #330, Individual #309, Individual #166, Individual #19, Individual #50 o DISCUS evaluations for the following individuals: • Individual #22, Individual #225, Individual #149, Individual #169 Individual #283,

	Individual #379, Individual #215, Individual #385, Individual #253, Individual #34, Individual #210, Individual #388 Individual #292, Individual #288 Individual #386, Individual #154, Individual #294, Individual #295, Individual #124, Individual #142 Individual #223, Individual #104, Individual #241, Individual #201, Individual #375, Individual #168, Individual #233 Individual #183, Individual #50, Individual #178, Individual #71, Individual #39, Individual #81, Individual #203, Individual #109, Individual #309 o MOSES evaluations for the following individuals: • Individual #22, Individual #225, Individual #149, Individual #169 Individual #283, Individual #379, Individual #215, Individual #385, Individual #253, Individual #34, Individual #210, Individual #388 Individual #292, Individual #288 Individual #386, Individual #154, Individual #294, Individual #295, Individual #124, Individual #142 Individual #223, Individual #104, Individual #241, Individual #201, Individual #375, Individual #168, Individual #233, Individual #183 Individual #50 Individual #178 Individual #71 Individual #39, Individual #81, Individual #127, Individual #203, Individual #109, Individual #309 <u>Interviews and Meetings Held</u>: o Donald Conoly, RPh, Pharmacy Director o Philip Roland, PharmD, MHA, Clinical Pharmacist o Ronnie Marecek, RPh, Staff Pharmacist o Andy Kathan, RPh, Contract Pharmacist o Rebecca McKown, MD, Medical Director o Joel Bessman, MD, Primary Care Physicians o John Burnside, MD, Primary Care Physician o Scott Lindsey, APRN, FNP o Jimmy Mercer, MD, Lead Psychiatrist o William Bazzell, MD, Psychiatrist o Angela Gardner, RN, Chief Nurse Executive o Lisa Owens, RN, Quality Enhancement Nurse <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Performance Improvement Team Meeting o Polypharmacy Committee Meeting o Pharmacy Department
	Facility Self-Assessment: The facility updated the POI on 11/22/11. The facility found itself noncompliant with all eight provision items. The motoring team agreed with the facility's self-ratings. The POI did not provide any details on how these self-ratings were determined. It provided for each provision item a series of actions that

	occurred to address the Settlement Agreement and the recommendations of the last review. Most of these actions related to development of policy and procedures that were needed. An action plan was also provided that provided the current status on the steps. Since much work needed to be done and implementation of most procedures had just occurred, there was very little in terms of data that could be reported. Facility leadership will need to closely monitor progress for each provision item. This will be difficult because the requirements are spread across multiple disciplines, such as medical, pharmacy, and nursing. The correct metrics will need to be chosen to ensure that those metrics monitored correspond to what is important t each provision item.
	Summary of Monitor's Assessment: In order to determine compliance with this provision, interviews were conducted with the pharmacy director, clinical pharmacist, staff pharmacist, medical director, medical staff, and QA Nurse. The monitoring team also attended meetings. Policies and procedures, meeting minutes, active integrated records, and multiple data sets were reviewed. At the time of the onsite visit, the pharmacy department was staffed with a pharmacy director, one staff pharmacist, one clinical pharmacist, and three pharmacy II technicians. A locum tenens pharmacist had also been working for several months. The pharmacy had taken several steps to move towards substantial compliance with the Settlement Agreement. The most important step noted was the hiring of a full time clinical pharmacist who was challenged by a department that had not made much progress over the past year. Within the first two months of employment, the clinical pharmacist had done a through assessment of the issues and became very familiar with the requirements of the Settlement Agreement. For the most part, policy and procedures had been developed and implemented just prior to the onsite review. Much of the data provided were based on previous processes. Nonetheless, it was good to see that the hiring of a full time clinical pharmacist had resulted in the very beginning of forward movement. Since the last onsite review, the pharmacy staff completed training on the use of the WORx software. It was anticipated that additional training was needed to fully utilize the capabilities of the system. A new policy related to prospective pharmacy reviews was implemented in December 2011. Pharmacy staff received training on this procedure and were fully aware of the expectations for documentation of communication with prescribers. Specific guidelines related to contacting physicians based on the level of the drug interactions were developed. The data submitted to document communication between prescribers and pharmacists, however, did not provide adequate evidence that these actions occurred. A new procedure related to the completion of Quarterly Drug Regimen Reviews was implemented just prior to the review. Unfortunately, the monitoring team discovered significant deficiencies related to completion of the QDRRs. The reviews were woefully inadequate in terms of content and actual formatting.

	There was an overall lack of professionalism in completion of the evaluations, with some documents containing doodling and name tracings. Moreover, numerous records encountered simply lacked the presence of the QDRRs for the last two quarters. A DUE policy was also developed and implemented. The policy did a nice job of summarizing the process and outlining requirements as specified in the Health Care Guidelines. Once again, this change occurred just prior to the review. DUEs were not completed as required, due to the lack of a clinical pharmacist for several months. A locum tenens pharmacist completed one review, but it had not been presented to the P&T Committee at the time of the review. The MOSES and DISCUS side effect rating tools were completed, but challenges remained with regards to the physician's participation in the process. The evaluations required that primary providers make a final determination related to the presence of side effects. This determination was not found in more than 20% of the evaluations completed. The ADR policy was revised to include important issues, such as a threshed for an intense review, but reporting of adverse drug reactions remained minimal. The facility made progress with the medication variance system. Although significant worked remained, the issue of overages and shortages was addressed, and significant improvement was measured. Many other steps occurred, such as increased nurse training that should contribute to improving the safety of the medication use system.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose	The policy Prospective Review of Medication Orders was approved on 11/17/11. Full implementation of the policy occurred in December 2011. The goal of the prospective review was to assure the appropriateness, safety, and effectiveness of the medications used. The policy outlined the steps used to achieve this goal: 1. The pharmacist or technician entered information into the WORx software. Medication was dispensed only after the order was entered. 2. The pharmacist reviewed all orders entered by the technician. 3. The pharmacist, in conjunction with WORx, reviewed the orders for allergies, indications, contraindications, etc. 4. Any questions regarding the orders were resolved with the prescriber and a written notation of these discussions and resolution was made in the Pharmacist Review of Physician Orders and Clinical Interventions Worksheet. This was the new format for maintaining documentation of communication between prescribers and pharmacists. The worksheet was maintained under the pharmacy department drive 5. The pharmacist contacted the prescriber for Level I and Level II drug interactions. The prescriber was provided a written monograph for Level III	Noncompliance

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	adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	interactions. Copies of Single Patient Intervention (SPI) data and Notes Extracts were requested for review by the monitoring team. The 27-page SPI document included 149 interventions documented by the pharmacists. Approximately 90% of the SPIs documented occurred during the month of October 2011 with the remainder having occurred in May. The majority of the SPIs were related to drug interactions and the outcomes of the discussions were not always clear. Interventions entered in late October 2011 began documenting expectations more clearly, such as "We need to document physicians response to drug information provided. What action did he/she take?" The content of the SPI was discussed with the clinical pharmacist and pharmacy director. Examples of the new documentation tool, known as the Pharmacist Review of Physician Orders and Clinical Interventions Worksheet, were provided and reviewed. This tool was fully implemented in December 2011 and included information related to (1) date of order, (2) medications involved, (3) problems with order, (4) physician response, and (5) resolution. These data were not provided to the medical director, but they should be. According to the pharmacy director, the department recently began using the notes extracts to document concerns related to diet and 180-day orders. Copies of the extracts from May 2011 through October 2011 were requested and reviewed. Two pages of notes were provided that consisted of 46 entities dated 11/7/11 and one entry dated 10/20/11. The majority of the notes documented diet textures. This provision of the Settlement Agreement also required that "Upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about ……the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature." In order to achieve substantial compliance with this provision item, the pharmacists will need access to laboratory data at the point of review of the prescription review. The pharmacy director and clinical pharmacist reported that there was no electronic access to lab data as labs were completed by a local community hospital.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as	The monitoring team engaged in several activities in order to determine compliance with this provision item. These activities consisted of interviews with the pharmacy and medical staff, review of policy and procedure, and evaluation of numerous documents. The facility selected and submitted a sample of QDRRs that were reviewed along with all	Noncompliance

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	appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	QDDRs that were included in the record sample. A new policy titled The Drug Regimen Review was approved on 11/17/11. This policy provided the framework and procedure for evaluating an individual's medication regimen retrospectively. According to policy, QDRRs were completed every 90 days and included a pharmacy review of allergies, contraindications, dose and route duplication of therapy, interactions, and proper utilization. Following completion by the pharmacist, The Quarterly Drug Regimen Review, which included the worksheets, was forwarded to the primary providers and psychiatrists for review. The total allocated turn around time from pharmacy review to physician review was 14 days. The QDDR form was also revised, but implementation had occurred just prior to the onsite review. All documents submitted to the monitoring team were completed in the old format. A total of 60 QDRRs were submitted for review. Each QDRR submitted consisted of one page that covered the general elements of the review, the pharmacist recommendations, and responses by the providers. The pharmacist, primary providers, and psychiatrists signed the majority of the documents. Thirty-nine of the 60 documents reviewed contained recommendations made by the pharmacists. Generally, the providers responded to these recommendations. Turnaround time often exceeded two weeks. The majority of the QDRRs submitted were completed prior to implementation of the two-week timeline. The medication regimens, normally included with any drug regimen review, were not provided with the document request. The monitoring team therefore could not review a full drug profile for each individual. A few examples of the findings are provided below. Agreement with the recommendation is indicated by (A), disagreement is indicated by (D), and no agreement or disagreement is indicated by ( ). N/A represents the actual provider response. Individual #266, 8/31/11 • Pharmacy comments: Consider repeat prolactin and obtain a baseline Vitamin D level. • Primary provider comments: Retest (A) Individual #144, 8/31/11 • Pharmacy comments: prolactin level elevated 5/11; TSH variable; neurology due 10/11 • Primary provider comments: psychiatry to review (A); will review data (A) • Psychiatry comments: none	

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		Individual #283, 8/31/11 • Pharmacy comments: "Vitamin D deficiency"; D2/D3?; triglycerides continue slightly elevated; chol? • PCP comments: will review data Jan 12 (A); satisfactory decrease on current tx (D) Individual #210, 8/31/11 • Pharmacy comments: prolactin 82 (changed to Vimpat 5/23); retest? • Primary provider comments: – psychiatry to review (A) • Psychiatry comments: none Individual #386, 8/31/11 • Pharmacy comments: vision showed crystals in cornea secondary to CPZ? d/c Thorazine or taper per consult 1/11; consider increasing Geodon • PCP comments: psychiatry to review (A) • Psychiatry response: none Individual #287, 8/31/11 • Pharmacy comments: baseline Vitamin D • Primary provider comments: Agree Individual #381, 8/17/11 • Pharmacy comments: request baseline vitamin D level; Moses score increased medical or clinical? • Primary provider response: will order (A) • Psychiatry response: N/A Individual #243, 8/18/11 • Pharmacy comments: ammonia increased 7/11, re-test; VPA low; baseline vitamin D needed • Primary provider comments: ammonia technically unreliable (D); will order (A) • Psychiatry comments: ammonia levels are unreliable Individual #38, 8/18/11 • Pharmacy comments: prolactin increased, retest? Zyprexa dose? • Primary provider comments: per Psych (N/A) • Psychiatry comments: retest ( ) Individual #330,10/14/11	

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		• Pharmacy comments: repeat lithium • Primary provider comments: individual not on lithium (D) • Psychiatry comments: d/c'd 9/18/11 ( ) Individual #313, 10/14/11 • Pharmacy comments: at max dose of clozapine 900 mg/day • Primary provider comments: – defer to psych ( ) • Psychiatry comments: NA An additional set of QDRRs was reviewed as part of the record audits. These QDRRs included the required medication regimen, which allowed for a better assessment of compliance with the requirement for appropriate monitoring. A few examples are presented below: Individual #179, • Pharmacy comments: Recommend stopping prednisone • Primary provider comments: See IPN 10/10/11 • Psychiatry comments: There were no comments related to status of hypothyroidism or hyperlipidemia. The previous QDRR was completed April 2011. Individual #109 • The record contained QDRRs dated 3/22/11 and 12/22/10. There was no current QDRR in the record. Individual #295, 9/20/11 • Pharmacy comments: Need baseline vitamin D; retest prolactin? • Primary provider comments: Rounds 10/10/11, vitamin D 62 (D) • Psychiatry comments: Will retest (A) The required pharmacy assessment was not completed. The review stated the last QDRR was 9/10. The recommendation to recheck Vit D was appropriate since the follow-up value would not have been done at the time of review. There were no comments on monitoring for hypothyroidism or olanzapine. Individual #203 • The only QDRR in the record submitted was dated 3/23/11. Individual #206 • The date of the review was not provided. None of the signatures were dated. The document was stamped received 10/3/11. The drug profile was printed	

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		8/3/11. Individual #278, • The QDRRs in the record were dated 12/22/10 and 3/23/11. Individual #293, 9/26/11 • Pharmacy comments: No recommendations • Primary provider comments: Signed 10/20/11 • Psychiatry comments: Signed 11/2/11 QDRRs dated 9/24/10, 5/2/10 and 2/23/10 were found in the record. Individual #274, 7/11 • There were no pharmacy recommendations and the review was not dated. • There was no monitoring associated with treatment for diabetes nor was there any monitoring associated with the use of new generation antipsychotics and other psychotropics. The following observations were noted by the monitoring team with regards to the QDRRs: • There were several records that did not contain current QDRRs or lacked the previous QDRR. • Laboratory and other required monitoring were not appropriately completed. • The anticholinergic burden, use of stat and PRN medications and seizure control were not addressed in the reviews. • While polypharmacy was acknowledged, the reviews infrequently included recommendations on how to address polypharmacy. • Documents were handwritten and sometimes illegible. Doodling was noted on several. • Medical providers did not consistently document explanations related to the QDRRs in the IPN. • The worksheets, considered part of the review by SGSSLC policy, were not provided. This limited the amount of information available to the monitoring team. • The medication regimens, normally provided with the QDRRs, were also not provided. While the pharmacist often documented some medications, the complete regimens were not known. The QDRR policy stated that laboratory monitoring would be performed in accordance with the Medication Audit Criteria and Guidelines (Exhibit B). This attachment was not included with the policy. The medical director stated that monitoring was completed per	

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		the facility's lab matrix. Moreover, the medical director provided the monitoring team with a copy of state issued guidelines on preventive care. These guidelines contained an additional set of lab monitoring protocols. The medical director acknowledged that multiple sets of criteria existed and a resolution was needed. While the facility was tracking several components of the QDRRs, including the presence of laboratory monitoring and physician response, a review of the tracking tool indicated that compliance was cited for lab monitoring when appropriate monitoring did not occur. The psychiatry assistant completed this process and the expectation for the psychiatry assistant to apply multiple criteria was not a reasonable one. P&T minutes dated 9/26/11, documented that the tracking process was not working because the QDRRs were being held up in the medical services office. Based on the QDRRs assessed, it appeared that none of the existing monitoring criteria were consistently applied. The facility will need to take several steps in order to meet compliance with this very important provision item. Many actions had already occurred since the hiring of the clinical pharmacist. Given a lack of overall progress related to this provision item, facility leadership should provide proper oversight to ensure the following occur: • QDRRs must be completed in a timely manner in accordance with the requirements for quarterly review. It is recommended that the facility census be utilized as a tracking tool to document that every individual has a review completed. The pharmacy director, medical director, and QA department should review this information. The process for tracking these data should not result in substantial delays in filing the reviews in the actual records. • The criteria used for monitoring should be consolidated. There must be consistency among all policies related to the agreed upon standards. • The pharmacy director should discuss with pharmacy staff the need to provide legible, neat, and orderly reviews. The QDRRs were a part of the official legal record of care and should not contain doodling, drawings, and other inappropriate writings. If at all possible, the documents should not be handwritten.	
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	The monitoring team was provided a draft of the policy Chemical Restraint Clinical Pharmacy Review. This procedure described the role of the pharmacist in the process of using chemical restraints. According to the POI, this policy was postponed because one of the medical staff wanted to discuss with the entire medical staff. It was reported that the Polypharmacy Committee met weekly to discuss issues related to medication polypharmacy. Minutes were not maintained for that meeting and the document requested stated none were available.	Noncompliance

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	restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Based on the review of the QDRRs from Section N2, there was no documentation of adequate monitoring for the endocrine and metabolic risks of the atypical antipsychotics. This will need to be addressed at the next review through the appropriate documentation in the QDRRs of the laboratory monitoring parameters	
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 provision item addresses two actions taken on the part of the primary providers, responses during prospective medication reviews as well as responses to retrospective reviews. Just prior to the onsite review, the pharmacy department embarked upon significant changes in policy designed to improve documentation of responses, tracking of responses, and corrective actions taken related to both of these. The full impact of those changes should be evident during the next onsite review. Information in the QDRRs, SPIs, and records was used to assess compliance with this provision item. As discussed in Section N2, there were several concerns related to the quality of QDRRs, including the relevance of the recommendations. Recommendations were often not made when they should have been and many that were made were vague. The SPI information regarding physician response to recommendations generated by prospective reviews was not recorded as discussed in section N1.	Noncompliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The most recent MOSES and DISCUS evaluations included in the record sample were reviewed along with those included with the record sample. The findings are summarized below: Forty four MOSES tools were reviewed: • 43 of 44 (98%) were signed and dated by the physician • 35 of 44 (80%) documented no action necessary • 9 of 44 (20%) documented no conclusion (BLANK) by the prescriber Forty three DISCUS evaluations were reviewed and showed that: • 42 of 43 (97%) were signed and dated by physician • 31 of 43 (72%) indicated no TD	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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11 of 43 (26%) documented no prescriber conclusion (BLANK)
1 of 43 (2%) documented persistent TD

Generally, there were no substantial delays between the transfer of information. Twenty percent of the MOSES evaluations and 26% of the DISCUS evaluations were not completed because they lacked the final prescriber review.

<u>Additional Discussion</u>
Per policy, the prescriber was responsible for completing the evaluation section of the DISCUS and its accuracy. The MOSES evaluation contained a section for prescriber review that included the conclusion and comments. The failure to complete the final sections resulted in an incomplete evaluation. The presence of the prescriber's signature alone did not fulfill the requirement for completion of the evaluations.
</td><td></td></tr>
<tr><td>N6</td><td>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.</td><td>
The ADR policy was revised in November 2011 to include a probability scale, a severity rating scale, and critical indicators for determining the need for an intense case review. The risk probability number was included as a means of proactively identifying potential problematic ADRs for intense review.

Four ADRs were reported for the months of October 2011 through December 2011.
<table>
<tr><th colspan="4">Adverse Drug Reactions</th></tr>
<tr><th>Reaction</th><th>Suspected Drug</th><th>Date</th><th>Outcome</th></tr>
<tr><td>Right pupil opaque; left pupil slow to react; admitted to Shannon hospital</td><td>Phenytoin</td><td>11/6/11</td><td>Referred to P&T for intense case analysis based on hospitalization</td></tr>
<tr><td>Decreased vision</td><td>Plaquenil</td><td>11/4/11</td><td>Offending agent removed, individual monitored. No additional action needed.</td></tr>
<tr><td>Possible psychosis versus delirium</td><td></td><td>11/4/11</td><td>Agent discontinued. No additional action necessary</td></tr>
<tr><td>Dilated pupil</td><td>Scopolamine</td><td>10/29/11</td><td>Required hospital admission. Offending agent removed and condition resolved.</td></tr>
</table>
Four ADRs were reported since the last visit. The facility did not maintain a comprehensive log, so no summary data ere submitted. One ADR was referred to the P&T
</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Committee for review. The facility should ensure that all health care professional and direct care professionals have completed adequate training. In order to increase reporting, consideration should be given to developing a list of triggers or signals that would prompt the pharmacist to further explore the possibility of an adverse drug reaction. The following are examples of potential triggers: • Prescribing an anticholinergic agent to someone who receives a drug known to produce EPS. • Hypokalemia noted in individual who takes a drug that is known to cause or worsen hypokalemia. • Documentation of C. difficile toxin in an individual who received a drug that is known to cause pseudomembranous colitis.	
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.	DUEs were not completed for five months due to the lack of a clinical pharmacist. The locum tenens pharmacist completed a review on the use of Keppra. This review had not been presented to the Pharmacy and Therapeutics Committee and was not submitted with the document request. It was included in the presentation book for Section N. There was, however, no actual DUE report provided. A document entitled Keppra DUE Audit was generated. There was no information related to the methodology utilized or how the sample size was chosen. The data collection period was also not known. Ten records were audited for appropriateness of indications, contraindications, and lab monitoring parameters. It was reported that there was 90% - 100% compliance with all criteria. This audit did not fulfill the requirement to complete a DUE because it lacked the essential components of a DUE. The clinical pharmacist had developed a very through policy that addressed the requirements of completing mediation reviews. This policy, approved in November 2011, just prior to the review, captured the relevant aspects of the requirement as outlined in the Health Care Guidelines. The monitoring team requested follow-up on corrective actions associated with the DUEs discussed during the May 2011 review. The pharmacy director indicated that problems were addressed and corrected, but there was no documentation of the corrective actions that occurred. The clinical pharmacist informed the monitoring team that a policy was recently developed to ensure that the Pharmacy and Therapeutics Committee provided oversight to the implementation and follow-up of corrective action plans.	Noncompliance
N8	Commencing within six months of the Effective Date hereof and with full implementation within one	The facility made progress with regards to the medication variance system. During the last review, the monitoring team stressed the importance of addressing the issue of overages and shortages because hundreds of medications were being returned to the	Noncompliance

#	Provision	Assessment of Status	Compliance
	year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	pharmacy. The facility implemented a reconciliation process in August 2011. The process started in the pharmacy, with the weekly medication exchange count. During that time, the pharmacist and nurse counted all medications. Once the medications were placed in the homes, nurses conducted medication counts with every shift change. This process, although labor intensive, had virtually eliminated the problem of medications being returned to the pharmacy with no explanation. That demonstrated and represented significant progress for the facility. The medication data for 2011 were provided to the monitoring team are summarized in the table below.	

Error Type	Apr	May	June	July	Aug	Sep	Oct
Omission	7	4	6	66	94	22	16
Wrong Time	0	1	0	0	5	0	0
Wrong Patient	0	1	1	1	1	0	1
Extra Dose	0	2	0	15	40	3	4
Dose Form	0	3	2	2	10	6	3
Wrong Technique	0	0	1	0	0	0	0
Wrong Prep	0	0	1	1	6	0	1
Wrong Route	0	0	0	0	0	0	6
Total	7	11	11	85	156	31	31

The monitoring team attended the Medication Variance Performance Improvement Team meeting, which discussed the following topics:

- Omissions – The PIT members believed there were several factors that contributed to the omission of medications. It was cited that nurses sometimes signed the MARs prior to administering meds. It was believed that a lack of time contributed to this because nurses reported needing more time and more help.
- Nurses often staffed two homes, which resulted in rushed medication passes.
- Medication room audits continued to show instances where medications were being pre-poured and pre-crushed. Copies of the audits were posted in the medication rooms. The staff believed that this was done to save time during med passes.
- Nurses were observed to have to utilize multiple MARS and medication carts during med passes.

The PIT members also discussed what measures were taken to improve medication administration and decrease errors:

- A preceptor program was established for new nurses.
- When possible, two nurses were allocated for med administration in high volume

#	Provision	Assessment of Status	Compliance
		homes. • Updated pictures were placed on rings to assist with identification of individuals. • As mentioned previously, medication reconciliation was occurring. This occurred for pills only. The clinical pharmacist reported that the state had a plan to move to unit doses for liquid medications. • A competency-training lab was established for nurses. Monthly medication classes were established for nurses who required additional training. The monitoring team previously made the recommendation to report and track all medication variances that occurred within the medication use system. It was noted that discussion related to medication errors focused on the type of variance and not the mode of variance. The pharmacy director reported that, on the day of the meeting, he received an order for Cipro 150 mg. Since that was a non-manufactured dose of drug, the physician was contacted and the order was cancelled. The pharmacy director reported that he captured this in the data on prospective reviews. The monitoring team explained that an order written for an improper dose of medication is in fact a prescribing error. The error was intercepted and cancelled, but it remained a "potential" error. Similarly, all potential errors should be reported. This data should be reported, analyzed, and trended. Moreover, it should be used to implement appropriate corrective active, training, and educational activities targeted at improving performance. Each discipline head should be responsible for implementing and documenting corrective actions for every error.	

Recommendations:

1. The pharmacy must document all interactions between the pharmacists and the clinicians. Documentation should include resolution of problems (N1).

2. Data collected on the interactions between the pharmacists and providers should be analyzed and trended. This information should be regularly provided to the medical director for discussion with the providers. Corrective actions should be taken as needed. There should be adequate documentation of actions and follow-up. Systemic issues identified as a result of data analysis should also be addressed (N1).

3. The facility will need to determine how to provide access to laboratory data to the pharmacist s for use during the prospective reviews (N1).

4. The pharmacy and medical departments should collaborate to develop a list of drugs that will require review of laboratory data prior to dispensing (N1).

5. Facility management needs to provide proper oversight of the QDRR process and ensure that every individual has a QDRR completed on a

quarterly basis. Tracking of the process should not result in delays for filing the documents in the records for use by the PSTs (N2).

6. The medical director, pharmacy director, and clinical pharmacist should collaborate n the QDRR tracking process. A professional with appropriate clinical knowledge will need to determine if the QDRR included the appropriate assessment of laboratory monitoring (N2).

7. A process for tracking should be developed, such that the compliance data regarding labs are valid and reliable (N2).

8. The medical director will need to ensure that there is consolidation of the various lab monitoring protocols. The Lab Matrix should be consistent with other policy/procedure and protocols (N2).

9. If the QDRR worksheets are considered as part of the review, they need to be included in the record. Consideration should be given to removing the QDRR worksheet as part of the actual report. The information contained in the worksheet should be summarized in the report (N2).

10. If an individual received medication for a condition and there is laboratory monitoring for that condition or medication outlined in the matrix, the values should be reported, preferably in tabular format. Tabular format will allow the medical providers and pharmacists to determine if the frequency of monitoring is appropriate. Moreover, it will allow for easy detection of trends in lab values. Lab values should be documented even when normal and reference values should be provided. The frequency of lab ordering should be in accordance with the facility's lab matrix or as clinically indicated (N2)

11. The pharmacy director needs to ensure that pharmacists completing the QDRRs complete them thoroughly, appropriately, and professionally (N2).

12. The medical director needs to work with the medical staff regarding the appropriate completion of the MOSES and DISCUS forms. The evaluations are not considered complete based on the presence of a signature. The prescribers must complete the prescriber portion of the evaluation (N5).

13. The pharmacy departments and medical departments should collaborate to develop training for all staff who may need to report suspected adverse dug reactions. This will require multiple levels of training targeted at specific disciplines (N6).

14. Consideration should be given to the development of a list of triggers or signals to prompt the pharmacist to further explore the possibility of adverse drug reactions (N6).

15. An ADR summary log should be maintained to improve data analysis. One way of accomplishing this is to utilize a simple spreadsheet that provides data on the specific drug, drug type, and reaction type (allergic, blood dyscrasias, elevated liver enzymes, etc.), in separate columns. Further description of the event and other comments could be put in a separate column. This would allow sorting by specific drug, drug type and drug reaction (N6).

16. The pharmacy director should develop a plan to ensure that fluctuations in staffing will not prevent critical services from being completed, such as QDRRs and DUEs (N7).

17. The facility must take several steps in advancing the medication variance system:
    a. All medication variances, actual and potential, must be reported.
    b. Data related to medication variances should include, but not be limited to, the distribution by nodes included on the reporting form, in addition to the distribution by type.
    c. There continues to be a need to track errors related to liquid medications. The reported plan to move to unit dose medications will make this an easier task to accomplish.
    d. The facility must implement strategies and systems that allow for detection of medication variances at every step of the medication use system.
    e. When the review of physician orders indicates that the wrong dose or wrong drug has been prescribed, the pharmacist should report a potential medication variance in addition to documenting the event in the intervention worksheet. (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o SGSSLC Organizational Chart o List of Individuals- Alpha o Admissions list o Section O Presentation Book and POI o Policy/Procedure: Minimum Common Elements of Clinical Care (10/6/11) o Policy/Procedure: Personal Support Team (PST) Monitoring (7/21/11) o Policy/Procedure: PNMT Process (11/3/11) o PST Mealtime Monitoring Form o Settlement Agreement Cross-Reference with ICF-MR Standards Section O-Physical Nutritional Management o Settlement Agreement Section O: Physical Nutritional Management Audit forms submitted o PNMT member list o CVs/resumes for PNMT members o PNMT Continuing Education documentation o QA/QI Council Quality Assurance Reports (May 2011 – October 2011) o Individuals with PNM Needs (11/2/11) o Individuals with No PNM Needs (11/2/11) o Documentation submitted for Mealtime and Enteral Nutrition PITs and Clinical IDT-At Risk Modeling o List of hospitalizations/ER visits/Infirmary Admissions o Program Effectiveness Tracking (11/15/11) o PNM Monitoring Tracking (mealtime, equipment, lifting, AAC, positioning, off home) September – November 2011 o Completed PNMP Monitoring Forms submitted o Completed Skills Drills submitted o Validation Tool templates o NEO training curriculum for PNM o NEO Specialized On Home PNM Training Curriculum o Non-foundational Training materials o Competency Based Training Sessions Foundational Skills (11/15/11) o Individuals at Risk for Choking, Falls, Skin Integrity, Pneumonia (Respiratory Compromise), Fecal Impaction (bowel obstruction/constipation), and Osteoporosis (11/17/11) o List of Individual Risk Levels by Building (11/18/11) o Integrated Risk Ratings o Dining Plan template (Revised 7/11)

	o Dining Plans and training sheets submitted o Individuals with Modified Diets/Thickened Liquids (11/9/11) o Individuals with Downgraded Diet Textures and Consistencies in the Past Year (11/1/11) o Poor Oral Hygiene for the Months of May – November 2011 o FY 2011 Chronic Respiratory Infections o FY 2011 Aspiration/Pneumonia o Pneumonia PIT information o Individuals with Choking Incidents with Heimlich Performed or Incident Classified as Choking with No Heimlich (11/16/11) o Choking Incidents with Interventions (11/12/11) o PIT Enteral Feedings meeting minutes/ agenda (11/15/11) o PNMT Meeting Minutes (5/6/11 – 12/7/11) o Follow-up documentation related to choking incidents since the previous review (Individual #186 and Individual #288) o Individuals with BMI Less Than 20 (11/1/11) o BMI Greater Than 30 (10/28/11) o Individuals with Greater Than 10% Weight Loss o Individuals with Diagnosis of Pneumonia – Textures, Consistency and MBSS (10/25/11) o List of Individuals That Had a Fall in 12 Months o List of individuals with enteral nutrition (11/9/11) o Individuals Who Require Mealtime Assistance (11/7/11) o Individuals Who Have Received a Diagnostic Swallowing Evaluation During the Past Year (11/15/11) o Aspiration Pneumonia/ Enteral Nutrition Evaluations for: • Individual #109, Individual #203, Individual #66, Individual #90, Individual #278, Individual #98, Individual #325, Individual #122, Individual #18. o Individuals With Pressure Ulcer During the Past Year (11/17/11) o Fractures (5/28/11 - 11/1/11) and (10/1/10 – 10/27/11) o Individuals who were non-ambulatory or require assisted ambulation (11/7/11) o Primary Mobility Wheelchairs (10/27/11) o Individuals Who Use Transport Wheelchairs (10/27/11) o Individuals Who Use Ambulation Assistive Devices (10/28/11) o Orthopedic Devices and Braces (11/9/11) o OT/PT Tracking o OT/PT Assessment Tracking (11/15/11) o PNMPs submitted o PNM assessment tool templates o PNMT Evaluations, PNMT Action Plans, PSPs, PSPAs for: Individual #217, Individual #66, Individual #150, and Individual #288 o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans,

	Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Joel Dominguez, Individual #122, and Individual #345 o PNMP section in Individual Notebooks for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Joel Dominguez, Individual #122, and Individual #345 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Joel Dominguez, Individual #122, and Individual #345 <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o PNMT members o PNMP Coordinators o Various supervisors and direct support staff o Enteral Nutrition PIT meeting o QA/QI Council meeting o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs
	Facility Self-Assessment: SGSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review per request. The POI did not identify what activities were conducted for self-assessment, but rather included dated

	statements related to a variety of tasks since completed. Also, there was no mechanism to determine how the facility had determined noncompliance the eight provisions in this section. They indicated that they were not incompliance with provisions O1 through O8. This was consistent with the monitoring team's findings. Section O monitoring using the Settlement Agreement Cross-Reference with ICF-MR Standards Section O-Physical Nutritional Management audit tool was routinely conducted with QA reliability checks. The sample was small and often did not include individuals who did not receive PNM or PNMT supports and services to the results were generally skewed. It did not appear, however, that the audits were used to determine compliance with the provisions. A list of action steps were included in the POI. Though these were listed as complete, many reflected processes that were being refined and the monitoring team looks forward to reviewing the effectiveness of these processes during the next onsite review. The actions listed in the plan did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, but were generally related to content in previous reports or specific recommendations made by the monitoring team. This plan, however, was a strong one though only designed for half of the provisions in this section. The director provided detailed documentation of completion of tasks in an effort to reflect a plan to direct focus, work products, and effort by staff, but the two parts of the plan were not clearly linked. Action steps should be short-term, and stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. Trend analysis should also be considered to present how the systems implemented have effected positive change with regard to the Settlement Agreement elements. Though significant improvements were evident, and a tremendous amount of activities were completed and a number of systems designed and implemented, the monitoring team found that SGSSLC continued to be in noncompliance for each of the items in provision O.
	Summary of Monitor's Assessment: The Habilitation Therapies department demonstrated a lot of effort with a substantial number of work products produced related to this provision and to section P below. There were many new systems initiated. The director clearly reviewed the previous report for all related sections and developed strategies to address issues identified. The PNMT at SGSSLC was fully constituted at the time of this review, though only the nurse was dedicated due to extremely low staffing. She was competent, energetic, and served as a strong point person for consistency and connection to other departments and programs. The monitoring team observed a meeting that showed that the PNMT was developing and refining a process to address new referrals for assessment and PNM supports, as well as to review individuals with other PNM-related concerns. They were attempting to integrate themselves well with the PST rather than to function as a stand-alone team. They

	also were working to effectively integrate the system of risk assessment into this process. The facility still had some way to go toward more effective discussions and decisions related to rating risk as well as in the development of appropriate action plans. The PNMT was integrating actions they need to take within the existing PST action plans. As their system evolves, attend to the tracking of clinical indicators and doing trending with analysis. The PNMT met on a weekly basis and regular attendance by some core team members was low, though there was an effort to ensure that a discipline specific designee was present at the meetings. There was only one dietitian for the entire facility and this impacted her availability to the PNMT, as well as the provision of supports to the PST for other individuals at the facility. She had not attended any PSP meetings for the sample reviewed. The PNMPs were of a consistent format and each was current within the last 12 months, though only a small number had been converted to the new format. Implementation of these plans, while improved, still posed challenges for professional staff and the PNMPCs to promote continued competency and compliance of direct supports staff. Positioning and transfers continued to be a concern. Food preparation and DSP responses to errors in food textures should be a focus over the next six months. Supervisors were not recognizing the problems and/or were not take sufficient corrective actions to address them. The PNMPCs appeared to have greater confidence in their roles as monitor and coach. The program effectiveness monitoring was a great step in determining whether interventions are effective, but direct therapy and SAPs designed and reviewed by the therapy clinicians was still extremely limited. The PNMPs were not well integrated into the PSP at this time. There were steps being taken to improve this including training of the QDDPs, though more assistance was indicated. The current strategies to include this information varied greatly in format and content. The integration of the PNMT action plan will likely result in improved integration for individuals followed by the PNMT, but not necessarily for other individuals with PNM needs. Integration will be key to appropriate integration of supports and mitigate risks of health issues and injury. The PSTs continue to require support regarding risk assessment and real time modeling by the Clinical IDT to effectively implement these new policies and procedures. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. The PNMT evaluations reviewed were essentially record reviews and did not reflect new data or more current assessments by any core team members. This will be key to successful resolution of issues that resulted in individual's need for PNMT supports. Specific assessments by OT/PT and nursing were to include head of bed assessments and wheelchair positioning studies. While these were excellent additions, functional skill assessments should also be conducted to determine changes in other domains as well. In addition, there was no evidence that the PNMT reviewed the findings of monitoring conducted to assess compliance with the PNMP or other plans or their effectiveness in meeting the intended goals as an aspect of the PNMT assessment. It would be critical to determine if the plans were appropriate and properly

	implemented. These should be key elements of the PNMT assessment. Assessment should be a look-behind of existing assessments to determine if findings or interventions were missed, overlooked, or not well implemented. Change in status assessments conducted by the PSTs were not consistently comprehensive in nature as described in section P below. Mealtimes were observed in a number of homes that had been observed during previous onsite visits. There was evidence of improvements related to compliance with the dining plans. Exceptions were primarily regarding food service issues with food preparation for chopped diets; the pieces were too big in some cases and too processed in the case of the fruits and vegetables. Others are identified below. There was also some emerging evidence of the effectiveness of the new system of NEO shadowing with new staff. There was an issue, however, with the support offered to staff who were pulled from one area to work in another. There was not a consistent system to ensure that they were appropriately prepared to apply PNM supports in the context of an understanding of their needs and risks.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally 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,	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** SGSSLC formally initiated the new process for the Physical Nutritional Management Team (PNMT) on 2/8/11. Core team members at the time of this onsite review were Dena Johnston, OTR, Director of Habilitation Therapies, Maria DeLuna, RN-BC, BSN, Erin Bristo, MS, CCC-SLP, Judy Perkins, PT, and Sally Nolen-Smith, LD, MBA. The physician membership rotated between Joel Bessman, MD and Scott Lindsey, RN, MSN, FNP-BC depending upon who was being reviewed. The nurse position was filled on 7/6/11 with a start date on 7/16/11. This was the only dedicated team member at the time of this review. Additional members who varied with the individual reviewed included nurse case managers, QDDPs, Home Managers, DSPs, and other PSTs as indicated. Resumes/CVs were submitted for each of the team members listed. PNM-related continuing education documented by the nurse and therapy members since the previous review included the following: state-sponsored PNMT Training, Introduction to PNMT, Annual Habilitation Therapies Conference, Introduction to GI/Dysphagia, and The Role of the Dietician in PNMT. Additional courses were attended by the nurse and the SLP. Continued participation in continuing education by al team members is critical to the success of this team to serve as a valuable support to the PSTs through education, assessment, the design and implementation of individual action plans and interventions, and to serve as system-wide agents of change and quality improvement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	**Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The PNMT met regularly at the time of this review. Meeting minutes were submitted for meetings held since the previous review in May 2011. Meetings were held approximately weekly from 5/6/11 through 12/7/11 (32). The meeting on 12/7 was conducted during this onsite review and attended by the monitoring team. Attendance by the core team members or a designee was as follows: • MD: 56% • FNP: 69% • PNMT RN: 53% (The first meeting attended by this member was 7/22/11. A RN case manager was attended most other meetings.) • OTR: 94% • PT: 100% • SLP: 72% • RD: 69% On 7/1/11, only a PT and home manager were in attendance. Each team member potentially had a backup designee in the case that the core team member was not able to attend. This was not available, however, in the case of the dietician because Ms. Nolen-Smith was the only RD employed at SGSSLC. Staffing was inadequate for OT, PT and SLP and was not acceptable related to nutrition services.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional	**Standard: A process is in place that identifies individuals with PNM concerns.** There were at least 177 individuals identified with PNM needs at SGSSLC, or, 73% of the current census (241). A policy and process used to establish health risk levels was implemented statewide in January 2011. The goal was to have discussions of risk occur during each individual's PST meeting. At the time of this review, the teams were continuing to work toward integrating this into the PSP process that had been initiated in the Fall 2010. Based on reviews of the risk assessments and associated action plans in PSP meetings, PNMT meetings and documents submitted, the facility continues to need improvement in this area to ensure that this system is useful in the provision of supports and services. Per the policy "PNMT Process," the PST was to refer individuals at high risk to the PNMT who were not stable and for whom they required assistance in developing a plan. Upon initial review, the PNMT assigned a level of involvement, rated 1, 2, or 3. The policy outlined roles and responsibilities of PNMT members and PSTs in the design and implementation of intervention action plans to address identified issues related to the	Noncompliance

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	management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	concerns that indicated the need for PNMT involvement. A number of the individuals currently followed by the PNMT had been identified as needing these services rather than as referred by the PSTs. The PNMT had conducted meetings in conjunction with the PSTs to provide rationale and to model risk assessment. During the PNMT meeting held and observed by the monitoring team, it was noted that the PNMT still needed greater experience in the clinical reasoning process related to risk assignment and the development of action plans. The Clinical IDT process (see section G) was yet another strategy to address this issue. The monitoring team looks forward to the likely progress the facility will make in this area over the next six months. A sample of PNMT assessments was submitted and included the following: Individual #150 (9/11/11), Individual #217 (8/22/11), Individual #66 (8/26/11), and Individual #288 (9/19/11). These assessments were, however, largely record review and not a reflection of a new, hands-on assessment by core team members. For example, these individuals had not received a more recent OT/PT assessment at the time of their review by the PNMT. Specific assessments by OT/PT and nursing, however, began to include head of bed assessments and wheelchair positioning studies. While these were excellent additions, functional skill assessments should also be conducted to determine changes in other domains as well. In addition, there was no evidence that the PNMT reviewed the findings of monitoring conducted to assess compliance with the PNMP or other plans or their effectiveness in meeting the intended goals. It would be critical to determine if the plans were appropriate and properly implemented. These should be key elements to the PNMT assessment. Meeting minutes documented discussion by the PNMT that included reason for referrals, weight, ideal body weight range, disposition or current status, and timeframe for subsequent review by the PNMT. Follow-up was generally conducted as indicated in the minutes, though this was not always consistent (e.g., Individual #273, Individual #210, Individual #78). In some cases, issues raised in one meeting were not revisited and status was not documented in the minutes (e.g., Individual #273, Individual #164, Individual #18). As of 8/11/11, the meeting minutes began to reflect review of individuals with change in status or health conditions that required close monitoring, such as hospitalizations, choking incidents pneumonia, skin breakdown, fractures, and dysphagiagrams. Consistent review of this information will permit a more proactive identification of needs for timely intervention.	
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,	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** As stated above, there were approximately 177 individuals identified with PNM needs provided with PNMPs. The PNMP format had recently been revised to address risks,	Noncompliance

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	oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	triggers, and outcomes expected related to the prescribed interventions and supports. The PNMPs were generally of a consistent format, though most of those submitted had not yet been revised to reflect the recent changes. The monitoring team selected 18 individuals for a record sample (included in the above list of documents reviewed). Comments are provided in detail below in hopes that the information will be useful to the facility. Overall, this was a very good set of PNMPs. As noted throughout this section of the report, improvements in implementation will be needed: • PNMPs were submitted for 18 of 18 (100%) individuals included in the sample. • PNMPs for 18 of 18 individuals in the sample (100%) were current within the last 12 months. • PNMPs for 18 of 18 individuals in the sample (100%) were current within the last 12 months. • PNMPs for 10 of 18 individuals in the sample (56%) were in the revised format. • In 18 of 18 PNMPs reviewed (100%), positioning was addressed. • In 5 of 8 PNMPs reviewed (63%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, primarily in supplement sheets with photographs and detailed instructions. • In 18 of 18 PNMPs reviewed (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 18 of 18 PNMPs reviewed (100%), the PNMP listed bathing instructions and listed equipment when needed. Some of the plans identified the number of staff needed for bathing, others identified the position. The PNMPs consistently listed the equipment needed. Only one of the PNMPs reviewed provided toileting instructions. • In 100% of the PNMPs reviewed for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. • In 18 of 18 PNMPs reviewed (100%), instructions related to mealtime were included. Dining plans were also submitted for 13 of 13 individuals included in the sample who received oral intake. • 5 of 18 individuals (28%) received enteral nutrition and this was identified in their PNMPs (100%). Instructions for no oral intake were not clearly stated in the PNMPs, however (0%). • In 18 of 18 PNMPs reviewed (100%), dining position for meals or enteral nutrition was provided. • In 12 of 13 PNMPs reviewed (92%), diet orders for food texture were included for those who ate orally. Assistance techniques for oral intake were consistently	

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		provided in the plans. • In 10 of 13 PNMPs for individuals who received liquids orally (77%), the liquid consistency was clearly identified. • In 13 of the 13 PNMPs for individuals who ate orally (57%), dining equipment, regular dinnerware, and utensils were not specified in the dining equipment section. • In 18 of 18 PNMPs reviewed (100%), a heading for medication administration was included in the plan. The content provided varied from plan to plan. • In 18 of 18 PNMPs reviewed (100%), a heading for oral hygiene was included in the plan. The content provided varied from plan to plan. • 18 of 18 PNMPs (100%) reviewed included a heading related to communication. Specifics regarding expressive communication or strategies that staff could use to be an effective communication partner were limited though improved on the newest revisions. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** With one exception, each of the PSPs submitted for the individuals included in the sample were current within the last 12 months (the PSP for Individual #76 expired the week of this onsite visit). PSP meeting attendance by PNM professionals was as follows for the 18 PSPs included in the sample (also see section F above): • Medical: 4 of 18 (22%) in attendance per the signature sheet. • Dental: 4 of 18 (22%) in attendance • Nursing: 18 of 18 (100%) in attendance • Physical Therapy: 5 of 18 (28%) in attendance • Nutrition: 0 of 18 (0%) in attendance • Communication: 0 of 18 (0%) in attendance • Occupational Therapy: 5 of 18 (28%) in attendance It would not be possible to achieve adequate integration given the limitations in PNM-related professional participation in the PST meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. Recent efforts to track attendance and to improve attendance was in place at the facility. Staffing vacancies were a significant barrier to improvements in this area impacting communication, collaboration, and integration of supports and services.	

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		Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff. As stated, above poor attendance at PSP meetings and the lack of integration in the PSP negatively impacted the development of the PNMPs in a comprehensive and collaborative manner. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** The Physical Nutritional Management Plan was referenced in 16 of 18 (89%) of the PSPs reviewed, however, there was evidence that the team had reviewed the elements of the plan in only a couple of cases. In some PSPs only the diet or weight aspects were mentioned. In the case of Individual #76, the PNMP was not referenced at all. In the other PSPs there was no consistency as to the manner or content of how the PNMP was addressed. It would be extremely difficult for staff to locate information needed to further understand the PNMP. The PNMP was not well integrated into the individual's PSP as a result. There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed by therapy clinicians as well as in routine PNM clinics, however, there was no evidence of consistent review by the PST in relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the assessments were included in the PSP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full PST. PNMT training had been provided for the PSTs. The QDDPs may require greater guidance as to consistent strategies to incorporate PNMP information into the PSPs and action steps. The PNMPs were updated by the therapy clinicians based on change in status or need identification and indicated in the plan by the revised date, the PSP date (annual) and by highlighting of new instructions that were added to the previous plan.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and	**Standard: Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.** PNMPs and Dining Plans were developed by the therapy clinicians with limited input by other PST members. Efforts to increase attendance at the PSPs, PSPAs and continued participation of other team members in some of the PNMP Clinics should ensure that there is improved PST involvement in the development of the plan. Generally, the PNMP was located in the individual notebook in the back of an individual's wheelchair, if he or she had one, or was to be readily available nearby, otherwise. In most cases, pictures	Noncompliance

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	during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	were available with the PNMPs related to adaptive or assistive equipment as well as various positioning strategies outlined in the plan. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright. General practice guidelines with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation and in individual-specific training provided by the therapists and PNMPCs. Additional instruction sheets with pictures were included for some individuals related to wheelchair or bed positioning and alternate positioning. These pictures were large and easy to see. In general, the plans were well organized. An audit system had been developed and implemented in September 2011 for review of the PNMPs by the PNMPCs (eight per month) to assess whether they met format and content criteria and this should lead to improved consistency with content. A database had been designed to track compliance scores in order to ensure corrective action as identified. Dining Plans were available in the dining areas. Though improved since the previous reviews, errors were noted in (a) staff implementation and (b) recommendations outlined in the mealtime plan portion of the PNMP and/or Dining Plans and the preparation of food texture modifications provided from the kitchen. Some examples are presented below in hopes that this detail will be useful to the facility: • In 511A, those who were on a chopped diet received food items that appeared to be a ground texture. This was an issue with quality assurance coming from the kitchen, but also reflected that staff did not due diligence in evaluating the food textures prior to serving it to the individuals. • In 516E, there was a pulled staff there to provide supports to individuals that presented with significant PNM concerns. There was no supervisor present (one staff was acting as charge) and no PNMPC. The pulled staff indicated that she had not been provided any information. • Individual #126 was positioned too far from the table and this was not noted by staff. Staff had to be prompted to correct her alignment. • Individual #127 did not eat his meal and the staff were asked about other opportunities to eat or be provided a supplement. The instructions in his diet plan conflicted with the reported practice of supplements in the case of a missed meal. • Individual #7 held up her cup numerous times for more to drink and no staff noticed or responded to this request. • Individual #328's Dining Plan stated that someone should near him for safety. He had begun his meal and no staff was seated near him. Later staff came to sit with him and provided a verbal cue to a drink. He did not respond. When prompted, the staff read the dining plan and began to offer physical cues that were more effective.	

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		• Individual #328 gulped the whole glass of tea without pausing or staff intervention to pause. Staff offered more tea and when Individual #328 began to gulp it down again, staff said, "slow down." This was not effective to address this problem. • In 512 B, staff were serving the individuals from the family style bowls rather than encouraging the individuals to serve themselves independently. The Home Manager present did not intervene until prompted to do so. • In home 504A, 11 individuals in the home were seated at the dining tables for over 10 minutes without food. • In home 511A, the vegetables served were too small for chopped texture. The casserole served had some pieces were too large. • Individual #130 was leaning to the left. When asked about this, the staff reported to the PNMPC present that this had been going on for a week. • King Ranch Casserole was served in 510 and the pieces of chicken were large. The chopped green beans were ground. The PNMPC identified this as a problem and informed this monitor. Knives were provided to staff to cut up the chicken. The knives were provided after the bowls were already placed on the table and staff had a more difficult time intervening to cut up the chicken before the individuals started to eat their meal. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** When asked, there was a greater number of staff who appeared to understand the rationale for the strategies included in the plan and many were more confident when asked about elements of the plan. This was good to see and was likely due to the skills drills and questions routinely asked during PNMP monitoring.	
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.	**Standard: Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.** The content and handouts for PNM-related training were excellent and appeared to be comprehensive. The PNMPCs provided this training. By report, the director audited the training one time a year for each trainer. CTD also conducted audits. All new employees assigned to 516 E/W, 509 B, 508A, and 510A were to spend the morning with the QDDP and the afternoon with a PNMPC on the second day of their assignment to these homes following the classroom NEO training. The PNMPCs focused on training to reinforce foundational training from NEO and specifically related to PNM issues for the individuals (non-foundational skills) in that home (the shadowing process). Competency for foundational skills was established in NEO (there were checklists for each) and via skills	Noncompliance

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		drills for non-foundational skills. Per policy, staff were not to be included in the ratio for the home nor could they be pulled to another home during the first five days of their assignment. Communication strategies outlined in the PNMP were addressed at that time. By report, the PNMPCs had been competency-trained to conduct monitoring and training in the area of communication. An outline of this four hour training had been developed and appeared to be comprehensive. PNM Skill Drills were also conducted to assess competency, with retraining and repeat drills conducted until competency was achieved. An employee agreement was signed by the new staff acknowledging that the PNMP must be followed at all times. A PNMP Tool Ring was provided to each new staff with key elements and reminders related to aspiration, choking, diet textures, liquid consistencies, dining plan use, and communicating with an individual who used AAC. It was planned to add clinical risk indicators to these rings in the future. Issues related to timeliness of completing the check-offs had been identified and the director was working to resolve it. **Standard: All foundational trainings are updated annually.** Annual refresher courses were currently being provided in classroom setting and a new iLearn format related to aspiration and mealtime training for existing direct support staff. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Training for individual-specific plans or changes to existing plans was conducted initially by the therapists. Any available staff and the PNMPCs were trained at that time and they, in turn, completed the cascade training of additional staff. They were checked off as competent to perform the skill and to train others. This was specified on the training rosters. Staff not deemed to be competent were not to be permitted to assist an individual alone. A pulled staff in home 516 had not received individual-specific training related to the PNMP or dining plans in that home. She was not able to answer questions related to the plans. **Standard: PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.** Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above. The current system of monitoring had recently implemented a system of targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate implementation of supports designed to mitigate PNM risks.	

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		Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP. See above.	
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.	**Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** PST mealtime monitoring in all homes was initiated in July 2011. Findings were reviewed in the mealtime PIT. A formalized procedure further established guidelines for consistent implementation of the monitoring system. The PNMP Monitoring Form and Skills Drills were used to monitor the PNMP and to review staff compliance/competency. A schedule for this monitoring of individuals by the PNMPCs had been established and was based on the risk levels identified by the PSTs. A system of program effectiveness had been implemented that involved review of direct and indirect supports by the Rehabilitation Therapy clinicians with findings to be discussed at the monthly Rehabilitation Therapy Clinical Supports meetings. A schedule based on risk levels had been established as well. The Program Effectiveness Tracking spreadsheet (11/16/11) was submitted and included findings from September 2011 and October 2011. Issues identified were directed to the PSTs. The use of corrective action plans and integration of monitoring into a collective tool for the PST and findings will be integrated into the PSP process. Inter-rater reliability of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. A database developed to track PNM monitoring also tracked the completion of validation checks with the PNMPCs, as well as the findings of those checks. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).** A monitoring form had been developed to address implementation of the PNMP, mealtime, lifting and transfers, use of AAC devices and wheelchair and bed positioning. A schedule was established to ensure that monitoring occurred during bathing, medication administration, or oral care at a prescribed frequency. The monitoring schedules continued to be refined with the intent to base frequency on	Noncompliance

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		health risk indicators. A database also was designed to aggregate data and to track compliance findings and analyze findings, issues, staff re-training, and problem resolution. **Standard: All members of the PNM team conduct monitoring.** The PNMT members monitored specific issues related to the individuals they reviewed as outlined in the action plans. Other more routine monitoring was conducted by the PNMPCs. **Standard: 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.** Trending information from PNMP monitoring was going to be reviewed by the PNMT in order to direct and focus staff training needs and systems change. However, as described above the PNMT did not routinely utilize this information for assessments and reviews. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** Immediate intervention was to occur if an individual was determined to be at risk of harm. The monitor was to notify the appropriate person, such as the charge, home manager, nurse, or therapist. The forms themselves provided a mechanism to document these actions or to document follow-up, but this was not consistently noted.	
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.	**Standard: A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.** The new health risk assessment process was introduced in January 2011 and the PNMT and PSTs continued to face challenges in order to fully implement this process. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Individuals with PNMPs were reviewed at least on an annual basis, or more frequently based on PST referrals, findings from scheduled monitoring, or other informal observations, as well as in PNM clinics. As described above, program effectiveness monitoring was initiated on a quarterly basis. The intent was to review fit, function, and effectiveness of these specific PNMP supports. In the case that an individual participated in direct therapy, progress notes were written, but because the goals were not generally measurable, documentation of progress was typically only anecdotal, rather than data	Noncompliance

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		based. The system continued to need to be more fully developed and refined so as to ensure assessment of the effectiveness of the plans on a regular basis, in addition to the PNMP and dining plan monitoring conducted by the PNMPCs.	
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.	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** There were 8 (3%) individuals who were enterally nourished. Two of these individuals were listed with pneumonia in the last year. Each was identified as NPO. There were approximately 20 (8%) individuals with pneumonia in the last 12 months. There were approximately 9 (4%) individuals listed with pneumonia in the last six months. None of these were listed with aspiration pneumonia, though there was no clear review to rule this out as a possibility. Each of these individuals was to receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation. Ten assessments were submitted for review. Only 60% of these were complete because a number of the key sections were left blank. Further, these did not include an action plan to address identified issues or the current interventions. There was a no analysis of findings, recommendations, or action plans. Measurable outcomes were provided in a few cases, primarily that the individual would not experience aspiration or pneumonia, but without careful examination of the current plan and its effectiveness toward that end. Consideration of return to oral intake was generally dismissed for those who received enteral nutrition. There was no implementation of a protocol for pathways to potential return to PO intake. The monitoring team expects significant and timely progress with these assessments prior to the next review. **Standard: People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.** All individuals who received non-oral intake in the selected sample had been provided a PNMP that included the same elements described above. **Standard: 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.** There was no formal protocol outlined for this process.	Noncompliance

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		Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). As stated above, assessments were reviewed and 40% were found to be unsatisfactory. SGSSLC will require continued modeling and coaching to ensure proper implementation of this process. **Standard: Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.** The intent of the PNMP and dining plans was to provide consistent and effective supports to minimize the incidence of aspiration, oral intake to promote weight maintenance, and positioning and assistance techniques to ensure safe eating and drinking. Further focus on these areas should occur as the At Risk and PNMT systems are refined.	

Recommendations:

1. An increase in nutritional staff was certainly indicated (O1).

2. Ensure that the PNMT functions as an assessment team that may include collaborative interaction and observation rather than merely a meeting forum to conduct record review and history. Evaluations must be based on new data or information in order to yield a new perspective to address specific issues that drove the referral to the team (O1).

3. Identify issues that require tracking relative to individuals evaluated by the PNMT, establish the baseline, gather new data over a prescribed period of time, then review the findings as a team in order to analyze the relevance to a problem or as evidence of a solution (O2).

4. Use a collaborative approach to assist the PSTs for improved activity analysis in the development of SAPs for teaching individuals to slow down or take smaller bites. Integrate strategies and prompts like taking a drink, using a napkin, or putting the utensil down for individuals who do not respond to verbal cues. Therapy staff should provide inservice training to staff regarding the appropriate use of physical prompts during meals to redirect (O4).

5. Consider a system of drills for modeling and coaching with staff, perhaps a "flavor of the week" approach. Selection of a particular theme with a focus of training, coaching and review would heighten staff awareness of these concerns and would likely yield overall improvements (O7-O8).

6. Ensure proper food preparation (O4).

7. The PSTs continue to require support regarding risk assessment and real time modeling by the Clinical IDTs to effectively implement these new policies and procedures. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks (O2).

8. Format of the PNMT meetings should be modified to encourage all team members to participate in the process. The meeting observed was predominately presented by the team nurse and others listened. Also any documents referred to in the meeting should be provided to all team members so that critical information can be more easily processed each. Merely listening to a large amount of detail can be difficult to take in and analyze properly (O1).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o SGSSLC Organizational Chart o List of Individuals- Alpha o Admissions list o Budgeted, Filled and Unfilled Positions (10/31//11) o Policy/Procedure: Competency Training and Monitoring of Physical Nutritional Management Plans o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and POI o Settlement Agreement Cross-Reference with ICFMR Standards Section P-Physical and Occupational Therapy o Settlement Agreement Section P: OT/PT Audit forms submitted o Rehab Therapy Clinical Supports Meeting minutes submitted o Individuals receiving direct OT/PT o OT/PT Assessment template o OT/PT Assessment Audit Tool o Sample of OT/PT Assessments and completed Audit Tools for OT (1) and PT (2) o QA/QI Council Quality Assurance Reports (May 2011 – October 2011) o Individuals with PNM Needs (11/2/11) o Individuals with No PNM Needs (11/2/11) o List of hospitalizations/ER visits/Infirmary Admissions o Program Effectiveness Tracking (11/15/11) o PNM Monitoring Tracking (mealtime, equipment, lifting, AAC, positioning, off home) September 2011– November 2011 o Completed PNMP Monitoring Forms submitted o PNM Maintenance Log (11/9/11) o Completed Skills Drills submitted o Validation Tool templates o NEO training curriculum for PNM o NEO Specialized On Home PNM Training Curriculum o Non-foundational Training materials o Competency Based Training Sessions Foundational Skills (11/15/11) o Individuals at Risk for Choking, Falls, Skin Integrity, Pneumonia (Respiratory Compromise), Fecal Impaction (bowel obstruction/constipation), and Osteoporosis (11/17/11) o List of Individual Risk Levels by Building (11/18/11) o Integrated Risk Ratings o Poor Oral Hygiene for the Months of May 2011 – November 2011

	o FY 2011 Chronic Respiratory Infections o FY 2011 Aspiration/Pneumonia o Pneumonia PIT information o Individuals with Choking Incidents with Heimlich Performed or Incident Classified as Choking with No Heimlich (11/16/11) o Choking Incidents with Interventions (11/12/11) o PIT Enteral Feedings meeting minutes/ agenda (11/15/11) o Follow-up documentation related to choking incidents since the previous review (Individual #186 and Individual #288) o Individuals with BMI Less Than 20 (11/1/11) o BMI Greater Than 30 (10/28/11) o Individuals with Greater Than 10% Weight Loss o Individuals with Diagnosis of Pneumonia – Textures, Consistency and MBSS (10/25/11) o List of Individuals That Had a Fall in 12 Months o List of individuals with enteral nutrition (11/9/11) o Individuals Who Require Mealtime Assistance (11/7/11) o Individuals With Pressure Ulcer During the Past Year (11/17/11) o Fractures (5/28/11 - 11/1/11) and (10/1/10 – 10/27/11) o Individuals who were non-ambulatory or require assisted ambulation (11/7/11) o Primary Mobility Wheelchairs (10/27/11) o Individuals Who Use Transport Wheelchairs (10/27/11) o Individuals Who Use Ambulation Assistive Devices (10/28/11) o Orthopedic Devices and Braces (11/9/11) o OT/PT Tracking o OT/PT Assessment Tracking (11/15/11) o Mat Assessments and PNM Clinic documentation for: • Individual #40, Individual #217, Individual #98, Individual #25, Individual #325 o OT/PT Assessments, PSPs, PSPAs and other documentation related to direct PT services for: Individual #26, Individual #78, and Individual #318 o OT/PT Assessments, PSPs, PSPAs for the following: • Individual #265, Individual #11, Individual #175, Individual #163, Individual #50, Individual #325, Individual #400, Individual #344, Individual #385, Individual #67, Individual #180, Individual #177, Individual #132, Individual #355, Individual #379, and Individual #217 o PNMPs submitted o PNM assessment tool templates o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six

	months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Joel Dominguez, Individual #122, and Individual #345 o PNMP section in Individual Notebooks for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Joel Dominguez, Individual #122, and Individual #345 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Individual #38, Individual #122, and Individual #345 <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o Judy Perkins, PT o Cindy Bolen, PT o Charis Worden, OTR o PNMT members o PNMP Coordinators o Various supervisors and direct support staff o QA/QI Council meeting o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs
	Facility Self-Assessment: SGSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review, per request. The POI did not identify what activities were conducted for self-assessment, but instead included dated statements related to a variety of tasks since completed. Also, there was no mechanism to determine how

	the facility had determined noncompliance the four provisions in this section. SGSSLC reported in the POI that they were in noncompliance with provisions P1 through P4. However, verbally, the Rehabilitation Therapy Director reported that she believed the facility was in substantial compliance with P1. Section P monitoring using the Settlement Agreement Cross-Reference with ICFMR Standards Section P-Occupational and Physical Therapy audit tool was routinely conducted with QA reliability checks. The sample was small and often did not include individuals who did not receive PNM or PNMT supports and services to the results were generally skewed. It did not appear, however, that the audits were used to determine compliance with the provisions. A list of action steps were included in the POI. Though a number of the actions were listed as completed, many reflected processes that were being refined and the monitoring team looks forward to reviewing the effectiveness of these processes during the next onsite review. The actions listed in the plan did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, but were generally related to content in previous reports or specific recommendations made by the monitoring team. This plan, however, was a strong one, though only designed for three of the four provisions in this section. The director provided detailed documentation of completion of tasks in an effort to reflect a plan to direct focus, work products, and effort by staff, but the two parts of the plan were not clearly linked. Action steps should be short-term, and stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. Trend analysis should also be considered to present how the systems implemented have effected positive change with regard to the Settlement Agreement elements. Significant improvements were evident, a tremendous amount of activities were completed, and a number of systems were designed and implemented, however, the monitoring team concurred that that SGSSLC continued to be in noncompliance for provisions P2 through P4. Though significant changes had been implemented to address the format and content of the OT/PT assessments via the implementation of the audit tool, the sample audited was extremely small and, based on the documentation submitted, the clinicians continued to require a great deal of editing and coaching in the revision of assessments prior to being submitted as final work products. The system was a sound approach and while the monitoring was not able to find SGSSLC in compliance with P1 at this time, if the process continued to be implemented and progress continued over the next six months, it would be likely that substantial compliance for this provision item P1 would be achieved.
	Summary of Monitor's Assessment: Staffing levels had remained stable since the previous review and remained inadequate to accomplish all the roles and responsibilities required. The assessment process observed during this review, however, had significantly improved. The report content had also improved, though the analysis of findings was scattered throughout the report and did not

	appear to be based on all of the objective data. A discussion of health risk issues with a description of functional limitations, skill abilities, and potentials for the development of an integrated therapy intervention plan, is required to provide a foundation for non-clinical supports and programs, and are essential elements to an appropriate clinical assessment. Information contained within the OT/PT assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective PST should then drive the supports and interventions via the PNMP and other more direct services. The measureable outcomes were limited to those related to risk management only and not to promote a change in functional status or skill acquisition. Many were not actually stated in measurable terms. The interval for reassessment was specified in 53% of all the assessments, based on the level of supports required, and 92% of those completed after 7/15/11. It continues to be confusing to the monitoring team as to the plan for completion of comprehensive assessments. For example, the assessment tracking spreadsheet documented the most current assessment and the most current update, as well as a proposed comprehensive assessment date. In many cases, the update was updating an assessment that had been completed as many as 16 years earlier. An assessment that old could not be considered comprehensive. The OT and PT clinicians conducted their annual assessments together and, in some cases, the SLPs participated in the assessment process as well. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services. There was a continued need for improved staff attention to the details of proper positioning and alignment in wheelchairs and dining chairs and compliance with the PNMPs. No one was observed being repositioned prior to the meal, and a number of individuals were not appropriately aligned or supported. Attention to personal body mechanics used by staff also continued to need improvement. Some staff were more confident in their responses to the monitoring team's questions and appeared have a better understanding of why they were doing what they were doing in relationship to the PNMP. This was likely associated with the skills drills and ongoing coaching and drills with staff related to risks and the rationale for interventions and supports. Continued implementation of this process was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues.

#	Provision	Assessment of Status	Compliance
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.	**Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.** Dena Johnston, OTR, continued as the department director. Current staffing was two full-time physical therapists (Cindy Bolen, PT and Judy Perkins, PT) and one full-time OT (Charis Worden, OTR). There were no OT or PT assistants. Support staff included an Orthopedic Equipment Technician, Rehabilitation Therapy Coordinator, a lead PNMP Coordinator and eight PNMPCs. Fabrication and maintenance of seating systems and other assistive technology continued to be conducted by onsite technicians. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseloads. Annual assessments or updates were completed by OT and PT, collaboratively. Some of those who did not have established PNM needs required occasional supports to address acute injuries, changes in health status, post-surgical needs or to address more chronic conditions associated with aging consistent with the general population. Many others would likely benefit from skill acquisition/enhancement programs related to movement, mobility, fine motor skills, and independence. As currently staffed, caseload ratios were 1:120.5 for PT and 1:241 for OT for the general census. There were 177 (73%) individuals living at SGSSLC identified as requiring PNM supports. Caseloads calculated based on PNM needs were 88.5 for the each PT and 177 for the OT. Only three individuals participated in direct PT and none in direct OT. The ratios were high, particularly for OT, and the levels of direct service were low. Continuing education documented for these clinicians included a program related to pressure ulcer management attended by 11 of the 15 professional clinicians. Each of the clinicians had participated in state-sponsored web-based courses on various topics, the Annual Habilitation Therapies Conference, and PNMT training. Judy Perkins and Chris Worden attended courses related to dementia and Ms. Worden also attended a course related to functional strength training for the aging spine. Continuing education hours totaled 16.5 for Cindy Bolen, 23.5 for Dena Johnston, 29.5 for Judy Perkins, and 27 for Chris Worden. **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** Assessments were completed rather than screenings. Most of the assessments were completed by both OT and PT and in some cases the SLP. Seven individuals had been admitted since the previous review through 11/17/11. Sample assessments for	Noncompliance

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		individuals newly admitted were requested and three were submitted. Per the date of the assessment, each was completed within 30 days of admission. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** OT/PT assessments were submitted for 19 of 19 individuals included in the sample selected by the monitoring team. Of those submitted, three were not current within the last 12 months (Individual #122, Individual #38, Individual #248). Of the remaining assessments, three were identified as Comprehensive Evaluations, six were identified as updates, and six others were Rehabilitation Therapy Assessments. Each was current in the last 12 months. There were two updates for Individual #295, dated 3/16/11 and 8/8/11, the second one due to a change in status following anterior disc fusion surgery related to cervical spinal stenosis. Additionally, the five most current assessment samples from each therapist were also requested and assessments for 15 individuals were submitted. These consisted of 10 OT/PT Comprehensive Evaluations, two Rehabilitation Therapy Assessments, and two comprehensive Admission Assessments. All were current within the last 12 months. As requested, assessment for new admissions were also requested with three submitted. Two were duplicated for Individual #175 and Individual #11, so only one of these was included for review (Individual #355). Additional assessments were submitted for three individuals who participated in direct PT (Individual #78, Individual #318, and Individual #26). The assessment for Individual #318 was duplicated in another request. The total number of assessments included for review was 32. Twenty-three of the 32 (72%) individuals were identified as having concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Others were generally independent, but a number required some limited supports. Most of the recommendations were for a variety of indirect services via the PNMP, the provision of assistive equipment, and/or orthotics, other consults, and dining supports. Direct intervention was recommended for Individual #78 and Individual #318 only. New comprehensive assessment and evaluation update formats were developed by the state and were implemented at SGSSLC by 7/15/11. These formats incorporated risk levels and guidelines to address the impact these have on function and a rationale for supports and services indicated to address these risks. An audit tool was developed at the facility in order to review assessments against the format and to shape content for improvement across clinicians. This was implemented on 9/26/11 per the POI and audits continued through the time of this onsite review. A spreadsheet was developed to track	

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		findings and training needed to ensure progress. The director met with each therapist regarding one assessment per month to review the audit scores and to make corrections. A monthly score was established for each clinician to allow for comparative analysis of improvement. There were three new admission assessments submitted as completed after 7/15/11 as well as seven comprehensive assessments, one assessment, and two updates. The new admission assessments and five of these comprehensive assessments were generally consistent with the current assessment format. Three of the comprehensive assessments did not address risk levels (Individual #385, Individual #400, and Individual #344). Each of the updates submitted were consistent with the state evaluation update format (Individual #295 and Individual #76). The analysis of findings section of the assessments reviewed was improved somewhat and provided a general rationale for most of the recommendations in the reports. It did not reflect, however, an analysis of all of the pertinent data addressed in the report and used for clinical reasoning in the development of the intervention plan for supports and services recommended. The measureable outcomes were limited to those related to risk management only and not to promote a change in functional status or skill acquisition. Many were not actually stated in measurable terms. The interval for reassessment was specified in 53% of all the assessments, based on the level of supports required and 92% of those completed after 7/15/11. It continues to be confusing to the monitoring team as to the plan for completion of comprehensive assessments. For example, the assessment tracking spreadsheet documented the most current assessment and the most current update as well as a proposed comprehensive assessment date. In many cases, the update was updating an assessment that had been completed as many as 16 years earlier (Individual #253). The update format indicated that the update should make reference to the previous assessment and present only information that was changed since that time. In this case, it would not be considered a stand-alone assessment and, as such, the comprehensive assessment should also be maintained in the individual record. It would be common practice then that the comprehensive assessment would not be purged until another was completed to replace it, and that subsequent updates would be maintained annually or at some other reasonable interval to ensure that critical information was available on an ongoing basis. For example, in the case of Individual #76, an update was completed on 11/20/11 and a comprehensive assessment dated 12/10/10 was referenced in that report, but was not present in his record. However, the current assessment listed in the assessment tracking sheet was dated 11/30/05 and the 12/10/10 report was listed as an update. Assessment audit tools were completed for one assessment per clinician per month. Compliance findings for two months ranged from 21% to 61% across the three therapists.	

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		The audit tool appeared to be comprehensive and thorough. This was an excellent method to shape the format and content of the assessments and updates as well as create opportunities for peer review and clinical case reviews. Some comments regarding the tool are below: • #3: This indicator cited PNM risks, though all risk indicators should be considered in the OT/PT assessment to ensure an understanding how all risk indicators may impact health and functional skill performance. • #12: This indicator required identification of any current Rehabilitation supports or interventions. A key element to the report would be the effectiveness of these supports and the manner in which they had successfully mitigated or minimized health risks or the effectiveness in achieving intended functional outcomes relative to skill performance. • #17: This indicator did not make reference to the establishment of a clear baseline for skill acquisition and measureable, functional goals particularly for direct therapy interventions. These may need to be in separate indicators. • #26: This indicator limits the concept of outcomes related to identified risk. As described in #17, clear outcome and measurable goals/objectives should be established for skill acquisition programs. • General: The format did not necessarily follow the format of the assessment itself making use of the tool awkward. The audit tool was not discrete enough to evaluate the quality of the analysis of findings. Specific issues noted relate to the assessments included: • Updates did not consistently make reference to a previous comprehensive assessment. Though the outline stated that only new or changed information would be included in the update, this was not stated in the update itself. Combined with no reference to a previous assessment, the update appeared incomplete. It would not be known if the clinicians omitted information or that an area was unchanged and, therefore, was not addressed in the update. • While there were very limited skill acquisition programs, in the case that these were in place, the assessments for those individuals did not provide any discussion of the progress achieved as a result of the intervention. The assessments did not consistently establish a baseline from which to measure change or progress through intervention. • Tremendous amounts of data were presented in the evaluations, though limited amounts were considered in an analysis of findings. • In many cases, analysis statements were scattered throughout the report and it was difficult to discern the clinical reasoning used by the clinicians to guide the development of an intervention plan(s) and recommendations.	

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		• Even though the assessments more consistently provided functional examples of systems level findings (e.g., range of motion, strength, muscle tone), this information was not consistently utilized to guide intervention. The descriptions of functional skills were significantly improved; this was a strength of these clinicians. • There was limited assessment as to the effectiveness of the interventions/supports. • Findings of monitoring by the PNMPCs were not noted in the assessments reviewed. There was a new section that was consistently addressed that outlined the frequency of monitoring required. The rationale for this was not stated however. • There was inconsistent comparative analysis of health and functional status from the previous year. • The analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update. • The focus of recommendations continued to be primarily on the provision of the PNMP rather than skill acquisition strategies. The assessments for which audits were completed was very small with one per therapist per month. The scores were very low and a great deal of editing was required by the director. This system will likely be successful in improving the quality and consistency of the assessments completed at SGSSLC, though there was still a need for progress in this area. With additional time to refine this system, the monitoring team would anticipate substantial compliance in this area by the next onsite review. **Standard: 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 OT/PT Assessment Tracking spreadsheet, there were approximately 60 individuals with a current assessment completed in 2011. There were 13 individuals with current assessments listed in 2010 with updates also completed in 2011. Other updates in 2011 (approximately 69) were for assessments completed from 1995 to 2009. There were 42 updates completed in 2010 and two in 2009. There were at least 27 individuals with a most current assessment dated from 1998 to 2009. It was of concern that this many individuals with identified PNM needs had not received an assessment in as many as 15 years per the documentation submitted. Assessments should be completed within 30 days of the identification of an issue or concern, and more immediately if there are urgent issues with potential for further injury	

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		or health and safety risks. • There were two updates for Individual #295, dated 3/16/11 and 8/8/11, the second one due to a change in status following anterior disc fusion surgery related to cervical spinal stenosis with hospitalization from 7/14/11 to 8/1/11. This should be a routine practice. • In the case of Individual #78, however, a consult was completed by OT (8/23/11) following a referral from the physician on 8/19/11 related to left hand contractures two weeks. A modified palm protector was to be fabricated. The OT also referred him to the regional hospital for evaluation to rule out Reflex Sympathetic Dystrophy (RSD) and treatment. A splint was provided on 9/26/11. There was no comprehensive OT/PT assessment (the previous one was 3/8/11). PNM clinic notes on 9/13/11 and 12/6/11 stated that his current plan continued to meet his needs. As described in section O above, there were a number of individuals with health and health risk concerns that would likely benefit from OT and PT supports and services. **Per the Health Care Guidelines, the comprehensive assessment should address the following:** • **Movement; Mobility; Range of motion; Independence; and Functional Status across each of these areas (Health Care Guidelines, VIII.B.2)** As stated above, the state-approved OT/PT assessment appeared to be comprehensive and the assessments reviewed generally addressed range of motion and movement skills, such as transfers and ambulation. Other functional skills were now more consistently addressed, particularly in the area of fine motor skills and activities of daily living, though improvements were still needed in this area. For example, there was usually no discussion of release, but rather general statements as to reach and grasp only. There was, unfortunately, still little to no consideration for the potential for learning new skills via training objectives. **Standard: 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.** Discipline-specific consults or updates were generally completed in response to PST referrals or for a change in status (Individual #128 and Individual #78). Documentation was limited to a brief progress note. Evidence of follow-up was limited. More comprehensive interdisciplinary assessments by PST therapists were not routinely conducted in the case of a fracture, choking incident, pneumonia, or other significant	

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		health event. For example: • Individual #295 was hospitalized for C3-6 spinal fusion with immediate re-hospitalization on 7/14/11 with septic shock, renal insufficiency and respiratory failure, and PEG tube placement due to aspiration. He returned to SGSSLC on 8/1/11 and a chairside assessment of oral intake was conducted by OT on 8/2/11. Recommendations were to discontinue pleasure feedings secondary to frank aspiration and to review weekly. There was no evidence that a comprehensive interdisciplinary assessment had been completed, though clearly indicated in this case. On 9/2/11, a note by nursing indicated that he had not participated in neuromuscular electrical stimulation (NMES) intervention as discussed with OT/PT. There had been no previous documentation by OT, PT or speech with regard to this case since the update on 8/8/11, nearly a month earlier. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** Health risk indicators identified by the PST were included in the more current assessment reports. A discussion of health risk issues with a description of functional limitations, skill abilities, and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs, are essential elements to an appropriate clinical assessment. Analysis by clinicians as to the potential impact of risks or actual incidence of PNM concerns should be addressed in greater detail in the assessments/updates. The risks addressed in the OT/PT assessment should be consistent with those established by the PST. Though, if at any time there was evidence that the risk rating should be modified due to a change in status, the PST should meet to review this. Information contained within the OT/PT report should contribute to the team discussion to determine risk levels. If there was a rationale for a difference in these ratings identified in the annual assessment, this should be stated in the report for PST consideration. Risk levels identified by the collective PST should then in turn drive the supports and interventions via the PNMP and other more direct services provided by the therapists to assist in addressing those concerns. • An OT/PT assessment was completed to address inconsistencies in the health risk ratings for Individual #210 with recommendations to adjust the risk ratings for aspiration based on data presented in the assessment. In other cases, however, the risks were reported as per the PST, but inconsistencies with OT/PT findings were not addressed sufficiently.	

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		Standard: Evidence of communication and or collaboration is present in the OT/PT assessments. The OT and PT clinicians conducted their annual assessments together and, in some cases, the SLPs participated in the assessment process as well. They appeared to generally work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services, as indicated. As described above, however, communication and collaboration was inadequate in the case of Individual #295 and Individual #288.	
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.	**Standard: Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP. Within 30 days of development of the plan, it was implemented.** Approximately 177 individuals at SGSSLC were identified with PNM needs and, as such, had been provided a PNMP. These were reviewed by the therapy clinicians as an aspect of the annual assessment and during scheduled reviews in the PNM clinic. Implementation of the plans was also monitored by the PNMPCs. As non-licensed clinicians, these staff were not qualified to make judgments as to efficacy of the plans. There was a system of asterisks to alert staff to specific changes in the plans. Program effectiveness reviews were conducted by the licensed therapy clinicians per an established schedule based on risk level. The PNMPs appeared to be updated in a timely manner relative to the annual PSPs and the PNM clinic reviews. Interventions beyond the PNMPs were limited with regard to minimizing regression and enhancing skills. A number of individuals were identified with limitations in fine motor and activities of daily living skills, though interventions to address these were not typically provided. Analysis was often limited to the statement that skills were limited due to cognition, thus, eliminating options for skill improvement in this area. PT interventions were reported to be in place at the time of this review for three individuals (Individual #78, Individual #318, and Individual #26) and assessments, PSPs, PSPAs and other documentation related to this service were submitted as requested. The rationale for these interventions and specific functional, measurable objectives were not integrated in the PSP as SAPs, assessment, or plan. Despite an order for therapy, the clinician had a responsibility to establish a clear justification for therapy and a specific plan of treatment with a baseline status and measurable, functional goals and outcomes. Likewise, continuing or discontinuing an intervention required an adequate and appropriate rationale and justification. All therapy-related interventions should be written as SAPs and included as an action step in the PSP. They should also be subject to routine PST review with reported data related to progress. This was not noted for the individuals participating in direct PT. For example:	Noncompliance

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		• Individual #78: The assessment was an update completed on 3/8/11. It was only reported that he participated in a walking program on the home and that he received direct PT services two times a week for strengthening and to increase his endurance for activity. The assessment did not review his current status or progress over the last year related to either of these interventions. It was stated that continuing to walk was a personal goal for Individual #78 and that he would be supported to do this by continuing both of these. The stated Rehabilitation goal was only to promote safe walking through the use of a rolling walker and gait belt assistance from staff. This same information was merely restated in his PSP (5/31/11). There were no PSPAs related to these interventions. The walking program was listed as a step to meet his health needs (Action Plan #3). There was no measurable outcome identified for this intervention. That he participated in direct PT was not included nor were there any measurable objectives identified. There was no baseline established for this intervention. On 11/21/11, he was reported to walk four to five feet and this was described as a decline in function six weeks earlier. On 12/2/11, the clinician stated that he no longer had the endurance to attempt gait training and that he was not making any progress. There was no plan documented and it was not clear if the therapy was to continue. • Individual #318: The OT/PT assessment was dated 1/18/11. It was reported that he attended a PT class three times a week for balance exercises and lower extremity strengthening exercises to address his risk of falls. It was also recommended that he use a cane, left AFO, and a motorized scooter for mobility outdoors. The frequency of his falls (12, up from nine the previous year) had increased. There was no baseline established as to lower extremity strength. There were no functional measurable objectives related to PT intervention. He was expected to have fewer falls due to using the cane, left AFO, ramps rather than stairs, a shower chair, and standby assistance from staff. The analysis did not justify how direct PT would impact this goal of improved strength and balance and reduced falls. His PSP dated 2/16/11, did not included a description of his mobility skills, his cane use or information about his AFO other than he would require an orthotist in the community. It was documented that he required staff supervision to use his motorized scooter. There was an action step to use his scooter to go to classes according to an agreement for its safe use. These were not outlined in the PSP or in the OT/PT assessment. A training objective was noted related to safe use of his motorized scooter. There were four objectives listed on the plan, but it was not clear which one he was working on. There was an action step that OT/PT and speech would look into a computer for him and help him to learn to use a keyboard. There was no evidence that OT, PT or SLP had addressed. • Individual #26: The OT/PT assessment was dated 1/25/11. It was reported that	

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		she participated in direct PT for her right knee. On 5/23/11, she was reported to have completed 200 repetitions on the recumbent bike with two pound weights on her ankles. There was no statement as to any functional measureable objectives for this intervention. No baseline or status of the purpose or effectiveness of this intervention had been reported in her assessment. There was no reference to a specific goal in this note. An analysis of progress was not documented and no plan was outlined to continue or to change the program. **Standard: Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.** As described above, findings were often not integrated into the PSP. Recommendations other than the PNMP were often not included and there was no evidence of therapist-designed skill acquisition plans or SAPs related to direct therapy services. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** The primary support provided was via the PNMPs. PNMPs for the individuals in the sample selected by the monitoring team were reviewed. Each had been updated one or more times in the last 12 months. PNMPs provided staff instructions or precautions related to assistance and supports for mobility, positioning, and transfers. Additional areas addressed included bathing and skin care, communication, and precautions. Medication administration and oral hygiene were consistently addressed in the plans. Mealtime instructions included dining equipment, diet texture, and liquid consistency. Other assistive equipment was included, as well. A new format had been developed for the PNMPs to better address risk indicators, outline intended health outcomes and list general and individual triggers for certain concerns. Of the plans reviewed, only 17% were of this new format. It was understood that these would be revised with each individual's annual PSP. A PNMP Audit was created and recently implemented that should assist in shaping the existing PNMPs to include all of the required elements in a clear and consistent manner. Consideration of completing these more quickly for those at higher risks was indicated to ensure that this critical information was readily available to staff. **Standard: 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.**	

#	Provision	Assessment of Status	Compliance
		Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The assessments inconsistently provided a rationale for the specific equipment recommended for use, though the rationale for the wheelchair seating was more consistently noted. There were no pictures related to equipment or positioning submitted with the PNMPs other than those included on the dining plan and the identification photo on the PNMP. Photographs provide a valuable source of information to staff about how to use the prescribed equipment and how to appropriately implement plans. Without these visual cues, errors are more likely. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were few intervention plans and the rationale for initiation of intervention was not generally clearly established. Documentation was inconsistent and did not adequately address progress or status. **Standard: 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.** In the case that an individual received direct therapy, documentation was noted for each contact/session, in some cases, or weekly in others. There was no evidence of monthly or quarterly summaries. The documentation was appropriately included in the integrated progress notes. The documentation reviewed related to OT/PT intervention did not provide a comparative analysis of progress from month to month. Reviews of the PNMP were conducted annually, upon referral, based on the findings of monitoring or during a routine scheduled PNMP clinic. There was evidence of the therapists addressing some issues identified through monitoring or referral, but documentation of follow-up through to resolution was inconsistent. Frequency of review in PNM clinic, effectiveness monitoring or monitoring by the PNMPCs was described in 95% of the assessments or updates submitted and dated in June 2011 or later. There was no justification stated for the frequency of monitoring or re-assessment.	

#	Provision	Assessment of Status	Compliance
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.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available, and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per generally accepted professional standards of care. There were pictures provided to illustrate optimal alignment and support for the intended individual. These should be considered a key element of the PNMP. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs, though this had improved since the last onsite review, per observations. Some individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, or the pelvis not well back into the seat of the wheelchair (e.g., Individual #78, Individual #18). No one was observed being repositioned prior to their meal, and some individuals were not appropriately aligned or supported. Attention to personal body mechanics used by staff also continued to need improvement. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** The content and handouts for PNM-related training were excellent and appeared to be comprehensive. All new employees assigned to 516E/W, 509B, 508A, and 510A were to spend the morning with the QDDP and the afternoon with a PNMPC on the second day of their assignment to these homes following the classroom NEO training. The PNMPCs focused on training to reinforce foundational training from NEO and specifically related to PNM issues for the individuals (non-foundational skills) in that home (the shadowing process). Competency for foundational skills was established in NEO and via skills drills for non-foundational skills. Per the policy revision dated 7/28/11, staff would not be included in the ratio for the home nor could they be pulled to another home during the first five days of their assignment. Communication strategies outlined in the PNMP were addressed at that time. PNMPCs had been competency-trained to conduct monitoring and training in the area of communication. An outline of this four hour training had been developed and appeared to be comprehensive. PNM Skill Drills were also conducted to assess competency, with retraining and repeat drills conducted until competency was achieved. An employee agreement was signed by the new staff acknowledging that the PNMP must be followed at all times. A PNMP Tool Ring was provided to each new staff with key elements and reminders related to aspiration, choking, diet textures and liquid consistencies, dining plan use and communicating with an individual who used AAC. Staff not deemed to be competent were not to be permitted to assist an individual alone. A substitute (pulled)	Noncompliance

#	Provision	Assessment of Status	Compliance
		staff in home 516 had not received individual-specific training related to the PNMP or dining plans in that home. She was not able to answer questions related to the plans. The PNMP Monitoring Form and Skills Drills were used to monitor the PNMP and to review staff compliance/competency. A schedule for this monitoring of individuals by the PNMPCs had been established and was based on the risk levels identified by the PSTs. A system of program effectiveness had been implemented which involved review of direct and indirect supports by the Rehabilitation Therapy clinicians with findings to be discussed at the monthly Rehabilitation Therapy Clinical Supports meetings. A schedule based on risk levels had been established as well. The Program Effectiveness Tracking spreadsheet (11/16/11) was submitted and included findings from September 2011 and October 2011. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** Staff were monitored for continued competence, but the schedule was based on the individual and, as such, it was difficult to determine which staff had been monitored for continued compliance and competency. **Standard: Staff verbalizes rationale for interventions.** Random interview of staff related to the rationale for interventions they provided was conducted and a marked improvement in the responses was noted. PNMPCs and staff both appeared to be more confident in their understanding of the plans. Continued coaching and drills with staff related to risks were indicated to ensure that they were able to recognize their roles and responsibilities in management of health risk issues.	
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	As stated above, adaptive equipment was reviewed on at least an annual basis at the time of the PSP assessments, in addition to review per referral by the PST to address fit and function. This was conducted by the licensed therapy clinicians The AT workshop technicians completed all maintenance and repairs as identified via monitoring system or as reported by direct support staff. Work orders were tracked in a log/database. By report all copies of work orders were maintained by the habilitation therapies department director and they were routed back to her upon completion. Assessments were conducted as needed for new seating systems or for modifications to existing systems. Specific mat evaluations documented this process. There were	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	concerns, however, with the timely provision of this equipment (e.g., Individual #447, Individual #16, Individual #518). Ongoing review of this process is indicated. There were eight PNMPCs and one supervisor who conducted routine monitoring for mealtimes, communication, lifting, transfers, and positioning. PMNP Monitoring forms (three) were used to conduct monitoring by the PNMPCs and therapists. This form addressed availability of plans, use of proper lifting and transfer techniques, appropriate positioning, and condition of equipment. The individual and direct support staff were identified. The monitor was to document corrective actions taken or required. The monitors were assigned and scheduled to cover all homes across all three meals. The schedule of monitoring was based on risk level. There were, however, no policies or guidelines to address the monitoring process, though procedures were in development, as described above. There was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. Staff were monitored as an aspect of the individual-specific monitoring conducted by PNMPCs and therapists. There was no method to track if this covered all staff who were responsible for implementation of PNMPs. There was no system to track the findings from any monitoring for use in decision making about staff training needs or drills. There were no SAPs submitted for review that required data collection by direct support staff or validation of implementation and documentation at this this time. As described above, in the case of Individual #447, the system of monitoring did not effectively identify significant concerns evident related to his physical and nutritional management supports, and these were not appropriately addressed by OT, PT, and his PST in a timely manner.	

Recommendations:

1. There is a significant need to develop programs to address increasing or expanding functional skills. Formal programming is indicated for a number of individuals. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P2).

2. Integrate direct and indirect supports into the PSP through the development of SAPs that include measurable goals with performance criteria. Ensure that there is a clear measure of progress related to the goals and that these and other critical clinical measures, as well as functional health status indicators, are used to justify initiation, continuation, and/or termination of interventions (P2).

3. Review the existing OT/PT assessment format to address summary/analysis. As currently written, these were not consistently sufficient to establish the rationale for the recommendations. It is recommended that a more concentrated analysis of objective data be implemented rather than having it scattered throughout the report to reduce redundancy and making it a more meaningful and user friendly document. The

development of a framework that included more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions in the PNM clinic and the written reports would be useful, particularly with the addition of new therapy clinicians. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, services and interventions were indicated. These should then be listed as recommendations. (P1).

4. Continued implementation of coaching and skills drills was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues. Consider focusing on a particular element of PNM each week. The topic could change from week to week or month to month (P3)

5. Clarify what constitutes a valid comprehensive assessment and subsequent updates. Ensure that updates reference a comprehensive assessment (P1).

6. Continue aggressive efforts to recruit OT/PT staff including OT, PT, COTA, PTA, and therapy technicians (P1).

7. Include oral hygiene status in OT/PT assessments not only positioning. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care (P1).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o SGSSLC Policy: Dental Services, 9/15/11 o SGSSLC Policy: Missed Dental Appointments, 9/15/11 o SGSSLC Policy: Desensitization and Intervention Policy for Dental Services, 8/11/10 o SGSSLC Policy: Dental Care – Toothbrushes, 5/18/10, 4/11 o SGSSLC Policy: Oral Care For Individuals With Dysphagia, 1/11/10 o SGSSLC Policy: New Employee Oral Care Training, 2/10/10 o SGSSLC Policy: Annual Examinations, 3/1/10 o SGSSLC Policy: Dental Appointment tracking, 3/5/10 o SGSSLC Policy: Emergency Dental Treatment, 2/23/10 o SGSSLC Policy: Medical/Dental Restraint and Sedation Minimum Guidelines, 9/9/05 o SGSSLC Organizational Charts o SGSSLC POI for Section Q o Presentation Book, Section Q o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Listing, General Anesthesia and Oral Sedations, May – October 2011 o Listing, Individuals with Medical/Dental Desensitization Plans o Listing, Individuals Recommended For Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Quarterly Oral Hygiene Ratings o Dental records for the individuals listed in Section L o Documentation of strategies for dental refusals the following individuals: • Individual #396, Individual #16, Individual #193, Individual #382, Individual #291 o Desensitization plans for the following individuals: • Individual #261, Individual #217, Individual #201, Individual #294, Individual #385, Individual #389, Individual #130 Interviews and Meetings Held: o Thomas F Anderson, DDS, Dental Director o Rebecca McKown, MD, Medical Director o Carly Dusek, RDH o Kim Woodward, Dental Assistant o Lisa Owen, RN, Quality Enhancement Nurse

	Observations Conducted: o Dental Department
	Facility Self-Assessment: The facility updated the POI on 11/22/11 and determined that it was in compliance with provision Q1 and in noncompliance with provision Q2. The POI section addressing Q1 did not state what activities occurred to determine the self-rating. Instead it listed a series of actions related to development of databases and policy and procedures. The action plan for Q1 focused on issues related to missed appointments. Quite notably, the POI and action plan did not addresses the recommendation from May 2011 to continue and improve efforts related to the suction toothbrushing program. It also did not provide any information related to the provision of timely annual assessments. With regards to item Q2, in the POI, the first entry was made in June 2011. The monthly updates provided data related to failed appointments and again reported on the development of a policy related to missed appointments.
	Summary of Monitor's Assessment: The dental clinic continued to provide basic dental services to individuals supported by the agency, but there was no demonstrable advance towards achieving compliance with the Settlement Agreement. Progress noted at the last visit related to desensitization and implementation of suction toothbrushing clearly showed regression. The staff were very clear in noting that the resignation of the full time hygienist in June 2011 created a significant problem because she was responsible for administering most of the programs related to the clinic. Creation of that vacancy resulted in a loss of momentum. Databases were created to track appointments, but it was documented that the data generation was problematic. This was evident from the various sets of data provided. Compliance with the requirement for completion of annual assessments varied widely from month to month and the percentage of failed appointments showed no significant improvement**.** The reported oral hygiene ratings showed some improvement. Following the last monitoring visit, there did not appear to be any development of desensitization plans for several months.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.</td><td>The dental clinic underwent staffing changes sine the last visit. The full time hygienist who was largely responsible for programmatic issues resigned in June 2011. A new full time hygienist was hired on 10/17/11. At the time of the onsite review, the clinic was staffed with a dental director, full time hygienist, part time hygienist, and a full time dental assistant.

The dental director acknowledged that many issues related to achieving compliance with the Settlement Agreement were overseen by the hygienist and her departure created a significant void in the department. As could be expected, the new hygienist, employed less than two months at the time of the review, was just becoming familiar with the agency and the requirements of the Settlement Agreement.

<u>Provision of Services</u>
The dental clinic provided basic dental services, including prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. The facility maintained a contract with a dental anesthesiologist. The total number of clinic visits and key category visits are summarized below. These data were provided to the monitoring team as a series of monthly charts that provided the number and percentages of the categories of appointments.

<table>
<tr><td colspan="6">Dental Data 2011</td></tr>
<tr><td></td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sep</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Prophylaxis</td><td>60</td><td>79</td><td>57</td><td>83</td><td>76</td></tr>
<tr><td>Restorative</td><td>18</td><td>36</td><td>14</td><td>32</td><td>13</td></tr>
<tr><td>Emergency Care</td><td>4</td><td>0</td><td>1</td><td>0</td><td>2</td></tr>
<tr><td>Extractions</td><td>2</td><td>8</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td>Exams</td><td>68</td><td>40</td><td>88</td><td>49</td><td>55</td></tr>
<tr><td>X-rays</td><td>9</td><td>29</td><td>27</td><td>8</td><td>13</td></tr>
</table>

These self-reported data were compared to the various lists submitted. Variations in data were noted. For example, the pie chart documented 18 restorative visits in May 2011, but the list of restorative appointments had four. Similar discrepancies were noted during other months. The POI pointed out that the dental director expressed concern to the SAC that “database information was coming out wrong.” The POI indicated that the clinic was given a spreadsheet to use.

<u>Emergency Care</u>
Emergency care was available during normal business hours. After business hours, the on-call medical physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Oral Hygiene The facility tracked oral hygiene ratings quarterly. The data provided by the clinic are presented in the chart below.	

Oral Hygiene Ratings (%) 2010 - 2011				
	Dec – Feb	Mar - May	Jun - Aug	Sept - Dec
Good	66	67	77	84
Fair	19	17	16	11
Poor	11	9	5	5
NA	4	7	2	0

During the last onsite review, the facility had implemented suction toothbrushing for a few individuals just prior to the review. The dental director reported that the suction toothbrushing program was under the supervision of nursing and that dental clinic simply made the recommendation for use of suction toothbrushing. A list was submitted that contained the names of 31 individuals recommended for treatment.

During meetings with the monitoring team regarding the integration of services, the medical director and chief nurse executive were asked about the status of the suction toothbrushing program. It appeared that no one had a precise answer for this question. It was reported that there were individuals who had been receiving this treatment and were supposed to receive this treatment. Nursing did not maintain a cumulative list of the candidates and information on clinical outcomes. The CNE stated that she was aware that teams were meeting and discussing the issue on an individual basis. There did not appear to be any coordination or true collaboration related to provision of this service.

The individuals who were referred for suction toothbrushing were those who were at highest risk for aspiration, such as those individuals with tracheostomies and those individuals who received all nutrition enterally. Once the recommendation was made and a physician order written, the treatment should have been provided.

The fact that the nursing, medical, and dental directors were unaware of the status of the program and did not know if any individuals were actually receiving this treatment indicated a lack of collaboration and a lack of attention to this important requirement. The recommendation to expand the suction toothbrushing program was the first recommendation for provision Q in the May 2011 report.

The dental director and hygienist reported that special precautions were taken with individuals who were at risk for aspiration. There did not appear to be any monitoring of this support provided by the habilitation department.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td>Policies and Procedures
As required, the facility developed a local dental services policy in September 2011. This policy was based on the dental policy issued by the state in August 2010. A policy addressing missed dental appointments was also developed in September 2011.

Annual Assessments
The facility provided a list of all annual assessments completed during the six months prior to the onsite review. The dates of the current and previous assessment were provided for comparison. The assessment was considered timely if it was completed no later than the calendar month of the previous year's assessment. Data tabulated from the list are summarized in the chart below.

<table>
<tr><td colspan="7">Annual Assessment Compliance Data 2011</td></tr>
<tr><td>Appointments</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td></tr>
<tr><td>Total Number</td><td>9</td><td>32</td><td>26</td><td>6</td><td>22</td><td>14</td></tr>
<tr><td>Timely Scheduled (%)</td><td>100</td><td>97</td><td>85</td><td>83</td><td>91</td><td>57</td></tr>
<tr><td>Completed (%)</td><td>78</td><td>75</td><td>96</td><td>100</td><td>86</td><td>79</td></tr>
</table>

The timeliness of scheduling annual assessments demonstrated marked variations. The completion of the actual assessments varied as well. Many of the failed appointments were due to refusals. Improvement in this area will require the facility to address the issue of failed appointments.

Dental Records
Dental records consisted of initial/annual exams, dental progress treatment records and documentation in the integrated progress notes. Providers documented in the integrated progress notes in SOAP format as required by the Health Care Guidelines.

Failed Appointments
The facility reported data on no shows, excused, refused, and total failed appointments. The data, as provided by the facility, are presented in the chart below.

<table>
<tr><td colspan="6">Dental Data 2011</td></tr>
<tr><td></td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sep</td></tr>
<tr><td>Total Visits</td><td>250</td><td>306</td><td>218</td><td>254</td><td>211</td></tr>
<tr><td>No Show</td><td>39</td><td>45</td><td>27</td><td>38</td><td>28</td></tr>
<tr><td>Excused</td><td>27</td><td>20</td><td>13</td><td>21</td><td>11</td></tr>
<tr><td>Refused</td><td>16</td><td>19</td><td>16</td><td>17</td><td>9</td></tr>
<tr><td>Total Failed</td><td>82</td><td>84</td><td>56</td><td>76</td><td>48</td></tr>
<tr><td>% Failed</td><td>33</td><td>22 (27)</td><td>25</td><td>30</td><td>30 (23)</td></tr>
<tr><td>Successful</td><td>168</td><td>222</td><td>162</td><td>178</td><td>163</td></tr>
<tr><td>% Successful</td><td>67</td><td>72 (73)</td><td>75</td><td>70</td><td>70 (77)</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		*( ) Data corrected by monitoring team During the last onsite review, on average, 71% of appointments were successful. For this review, there was no significant change with 72% of appointments successfully completed. The dental clinic notified QDDPs, home mangers, unit directors, the medical director, and the facility director of failed appointments. The PSTs were requested to provide strategies to decrease failed appointments. The following are examples of responses from the PSTs: • Individual #396, 11/17/11 - The PSPA noted the failed appointment on 11/10/11. The individual reported not knowing about the scheduled appointment. The home log book had no record of a scheduled appointment. • Individual #291, 10/11/11 – The PST identified the refusal on 10/6/11. This appeared to be an oversight on the staff as observations did not reflect any conflict or behavioral reasons for refusal. • Individual #16 – The QDDP entry noted the identification of a refusal on 10/3/11. The PST found this refusal to be an isolated incident related to psychiatric instability and the matter was referred to psychiatry for review. • Individual #382, 9/27/11 – The PSPA documented that the individual was not aware of the appointment on 9/7/11 and staff did not document a refusal. The log book did not record an appointment scheduled for that day. • Individual #193, 10/11/11 – The PSPA entry noted the individual reported not knowing about the appointment. The log book also did not record a scheduled appointment. Based on responses from the PSTs, it appeared that several individuals missed appointments, but may not have refused treatment. A lack of a scheduled appointment in the home log book supported those claims. The monitoring team also noted that the PST responses were all generated over the past two months. <u>Desensitization</u> The facility continued to utilize oral sedation and TIVA to facilitate dental treatment. Approval by the Human Rights Committee was required for the use of pretreatment sedations. The facility had implemented the use of a pretreatment sedation form. This was an attempt to ensure that medical, dental, psychology, pharmacy, and psychiatry collaborated on the use of pretreatment sedation. Data on the use of sedation and general anesthesia are summarized in the chart below.	

#	Provision	Assessment of Status	Compliance

Sedation and Anesthesia 2011						
	May	June	July	Aug	Sept	Oct
Oral Sedation Use # Individuals	1	0	0	4	0	0
TIVA # Individuals	0	9	1	0	0	8

On 10/20/11, a series of emails listing the names of 61 individuals was sent to psychology staff indicating that the individuals were being referred for an assessment for dental treatment. The monitoring team requested the names of all individuals with medical/dental desensitization plans. A spreadsheet, with 61 names, was provided. It did not indicate if the plans were medical or dental desensitization. There were implementation dates associated with eight individuals. Four plans were implemented in October 2011, three in May 2011 (Individual #217 and Individual #130), and one in September 2011. Overall, five new plans were implemented since the last onsite review.

The monitoring team inquired about the overall status of the desensitization program. The dental director indicated that desensitization efforts had essentially ceased for several months and the series of emails sent on 10/20/11 was an effort to restart the program in preparation for the December 2011 onsite review.

Additional Discussion

The facility had an overall failed clinic rate of 28%. Efforts to address the refusals appeared to be concentrated during the last few months. Sixty-one referrals were made to psychology in late October 2011 and the majority of the PST strategies to overcome barriers to treatment were generated during October 2011 and November 2011.
It is clear that the facility must re-evaluate the approach to desensitization and failed appointments. Achieving compliance with the Settlement Agreement will require efforts being ongoing and measurable progress demonstrated. This cannot be achieved with cyclical efforts.

Recommendations:

1. The facility will need to correct issues related to the data management in order to provide accurate data related to the types of services provided. Accurate data are also needed to assist the facility in determining the quality of services provided (Q1).

2. Since the provision of suction toothbrushing is an important modality in reduction of complications associated with aspiration, the monitoring team suggest that a formal process be developed and that it include the following:
    a. The medical and dental departments should collaborate to identify appropriate candidates.
    b. The nursing, medical, and dental departments should all maintain a list of individuals receiving suction toothbrushing.

c. The results of the treatment should be periodically reviewed and the plan adjusted as appropriate.
d. Data related to suction toothbrushing and clinical outcomes should be used by the Pneumonia PIT (Q1).

3. The dental clinic will need to ensure that those who require special supports related to positioning have those needs met and there should be a process in place for monitoring that this occurs. (Q1).

4. Annual assessments must be scheduled and completed in a timely manner. When that does not occur, a clear explanation and strategy should be documented in the records (Q2).

5. The facility must review the issue of failed appointments and ensure that responses and strategies are continuous and ongoing (Q1).

6. The dental clinic staff, home mangers and unit directors need to determine the point of breakdown in communication that attributed to a failure to appropriately document appointments in the home log (Q2).

7. Efforts at desensitization must continue. Individuals deemed potential candidates must be evaluated by psychology to determine the appropriateness for implementation of a plan (Q2).

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SGSSLC Organizational Chart o List of Individuals- Alpha o Admissions list o Budgeted, Filled, and Unfilled Positions (10/31/11) o Speech Staff list o SLP Continuing Education documentation o Section R Presentation Book and POI o Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines o Settlement Agreement Section R: Audit forms submitted o Rehab Therapy Clinical Supports Meeting minutes submitted o Individuals receiving direct speech services o Communication Assessment template o Program Effectiveness Tracking (11/15/11) o PNM Monitoring Tracking (mealtime, equipment, lifting, AAC, positioning, off home) September 2011 – November 2011 o Completed PNMP Monitoring Forms submitted o Completed Skills Drills submitted o PNM Maintenance Log (11/9/11) o Completed Skills Drills submitted o Validation Tool templates o NEO training curriculum for PNM o NEO Specialized On Home PNM Training Curriculum o Non-foundational Training materials o Competency Based Training Sessions Foundational Skills (11/15/11) o Individuals at Risk for Choking, Falls, Skin Integrity, Pneumonia (Respiratory Compromise), Fecal Impaction (bowel obstruction/constipation), and Osteoporosis (11/17/11) o List of Individual Risk Levels by Building (11/18/11) o Integrated Risk Ratings o Poor Oral Hygiene for the Months of May – November 2011 o FY 2011 Aspiration/Pneumonia o Pneumonia PIT information o Individuals with Choking Incidents with Heimlich Performed or Incident Classified as Choking with No Heimlich (11/16/11) o Choking Incidents with Interventions (11/12/11) o PIT Enteral Feedings meeting minutes/agenda (11/15/11)

	o Follow-up documentation related to choking incidents since the previous review (Individual #186 and Individual #288) o Individuals with BMI Less Than 20 (11/1/11) o BMI Greater Than 30 (10/28/11) o Individuals with Greater Than 10% Weight Loss o Individuals with Diagnosis of Pneumonia – Textures, Consistency and MBSS (10/25/11) o List of individuals with enteral nutrition (11/9/11) o Individuals Who Require Mealtime Assistance (11/7/11) o Individuals with AAC devices (11/15/11) o Individuals with Behavioral Issues and Coexisting Language Deficits (11/15/11) o Individuals with PBSPs and Replacement Behaviors Related to Communication o Individuals with PBSPs o Communication Master List o Tracking Log of Completed Assessments (11/15/11) o Communication Assessment template o Communication Assessments for individuals recently admitted to SGSSLC: • Individual #6, Individual #245, Individual #363, and Individual #157 o Communication Assessments, PSPs, PSPAs and other documentation related to direct speech services for: • Individual #66, Individual #265, and Individual #295 o Communication Assessments, PSPs, PSPAs for the following: • Individual #44, Individual #179, Individual #384, Individual #165, Individual #198, Individual #253, Individual #251, Individual #154, Individual #211, Individual #150, Individual #111, Individual #185, Individual #25 o PNMPs submitted o PNM assessment tool templates o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Individual #38, Individual #122, and Individual #345 o PNMP section in Individual Notebooks for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318,

	Individual #38, Individual #122, and Individual #345 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #66, Individual #90, Individual #278, Individual #76, Individual #128, Individual #295, Individual #210, Individual #22, Individual #288, Individual #127, Individual #248, Individual #7, Individual #222, Individual #153, Individual #318, Individual #38, Individual #122, and Individual #345 <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o Susan Reeves, MS, CCC/SLP o Erin Bristo, MS, CCC-SLP o PNMP Coordinators o Various supervisors and direct support staff o QA/QI Council meeting o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs
	Facility Self-Assessment: SGSSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Habilitation Director review the Presentation Book onsite and a copy was submitted for review per request. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements related to a variety of tasks since completed. Also, there was no mechanism to determine how the facility had determined noncompliance the four provisions in this section. SGSSLC reported in the POI that it was in noncompliance with provisions R1 through R4. Section R monitoring using the Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines audit tool was routinely conducted with QA reliability checks. The sample was small and often did not include individuals who did not receive PNM or PNMT supports and services to the results were generally skewed. It did not appear, however, that the audits were used to determine compliance with the provisions. A list of action steps were included in the POI. Though a number of these actions were listed as complete, many reflected processes that were being refined and the monitoring team looks forward to reviewing the effectiveness of these processes during the next onsite review. The actions listed in the plan did not reflect

	a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, but were generally related to content in previous reports or specific recommendations made by the monitoring team. This plan, however, was a strong one, though only designed for two of the four provision items in this section. The director provided detailed documentation of completion of tasks in an effort to reflect a plan to direct focus, work products, and effort by staff but the two parts of the plan were not clearly linked. Action steps should be short-term, and stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. Trend analysis should also be considered to present how the systems implemented have effected positive change with regard to the Settlement Agreement elements. Progress was limited in this area in large part due to the poverty of speech clinicians and as such the monitoring team concurred that that SGSSLC continued to be in noncompliance for provisions R1 through R4.
	Summary of Monitor's Assessment: A full time SLP began working at SGSSLC on 12/1/11. She had previously been a contracted clinician, so was familiar with the systems at SGSSLC. This permitted her to immediately take on roles and responsibilities with limited need for significant orientation. Progress with completion of communication assessments per the Master Plan was slow, in large part, due to extremely low staffing levels. This plan prioritized individuals based on their needs for communication supports, particularly AAC. A number of individuals were identified as requiring a re-evaluation in the last year that had not been provided per the Master Plan (50% of those identified as Priority 1). Still, others were completed, but after the PSP meeting. Without a current and comprehensive assessment, it is not possible to identify communication needs for AAC, communication programming, and intervention. As such, the number of individuals with AAC needs was not fully appreciated at this time, so it was likely that there were individuals with unmet needs for communication supports. Consistency of the implementation of AAC and communication plans continued to be problematic. Clinical staff had limited time for inserting themselves in the environments and daily routines of individuals, but this will be key to effective assessments, the selection of meaningful and useful communication supports, the development of communication programs, and to provide modeling of how to be an effective communication partner. There had also been a concerted effort in working with the teams related to communication, particularly for those who had challenging behaviors. Additional efforts and focus needs to occur in each of these over the next six months. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority.

	This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff, and to assist in the development of activities for individuals and groups.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Standard: The facility provided an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training included augmentative and assistive communication.** The department director was Dena Johnston, OTR. At the time of the onsite monitoring review, there was one full time SLP (Erin Bristo, MS, CCC-SLP) as of 12/1/11, and two part time contract clinicians, Susan Holler, MS, CCC/SLP (less than 30 hours per week) and Susan Reeves, MEd, CCC/SLP (32 to 40 hours per week). The contract positions were utilized due to staffing shortages and difficulties filling the state positions. A part time speech assistant had been providing approximately 16 hours per week, but would no longer be available after the week of this onsite review. Another speech assistant provided only four hours per week. There was one full time audiologist. There was one speech coordinator. There was one unfilled state positions for SLPs and one for a speech assistant listed. The ratio identified by the facility as of 10/31/11 was 1:241 though actual, approximate ratios based on the current census and hours provided by the clinicians were as follows: Erin Bristo (1:100 individuals), Susan Reeves (1:79 individuals), and Susan Holler (1:62 individuals). Ms. Bristo was generally responsible for the day to day needs related to communication and mealtime supports was a member of the PNMT, while the contract clinicians generally were responsible for completion of assessments. Ms. Holler also participated on the PBSP and SAP Committees. A current professional license was verified online for each of the speech clinicians listed above. Communication-related continuing education since the previous review included the Annual Habilitation Therapies Conference (11 hours each) and Effective Sensory Diets (6 hours each) listed with attendance by Erin Bristo and Susan Holler. Additional courses attended included Assessment of Technologies (Susan Holler, one hour) and Ethics for Speech-Language Pathologists (Susan Reeves, two hours). SLPs in this setting would typically be responsible for assessments, attending PSPs and PSPAs, provision of supports and services, program development, staff training and monitoring in the areas of communication and/or mealtimes. Though this level of staffing was increased by one full time position since the previous review effective only since 12/1/11, adequate and appropriate communication services had not been provided for the individuals who presented with significant communication deficits at SGSSLC as outlined below.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Standard: Communicative Aids and Speech Generated Devices (simple and complex) were provided to individuals based on need and not staff availability. All individuals in need of AAC, received AAC. SLPs actively participated in all facets of care in which communication is relevant. The SGSSLC Master Plan was requested and submitted. Three priority Levels had been previously described. There were 224 individuals listed in the Master Plan with at least 17 individuals not included based on the current census of 241. Per the plan, identification of priority level was as follows: • Priority 1 (35 individuals) • Priority 2 (27 individuals) • Priority 3 (36 individuals) • Priority 4 (89 individuals) • Priority 5 (37 individuals) There were 84% of the individuals listed across all priority levels who were identified as having a BSP. Completion of assessments in the last 12 months across each level was as follows: • Priority 1 (12/35, 34%) • Priority 2 (19/27, 70%) • Priority 3 (3/36, 8%) • Priority 4 (5/89, 6%) • Priority 5 (2/37, 5%) While these assessments were current within the last 12 months, a revised comprehensive assessment format was established by the state, effective 10/20/11. All individuals newly admitted to SGSSLC were to receive this assessment. Speech also began to integrate their evaluation updates with OT/PT for individuals who received direct or indirect communication services and supports. These were currently to be aligned with the PSP schedule. Subsequent updates for individuals with older existing communication assessments should be more comprehensive, by applying the content areas of the new state format. A number of individuals were identified as requiring a re-evaluation in the last year that had not been provided per the Master Plan (50% of those identified as Priority 1). Others had completed assessments after the proposed evaluation dates per the Plan as follows: • Priority 1 (14%) • Priority 2 (85%) • Priority 3 (19%)	

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		Some individuals (Individual #287, Individual #134, Individual #323, Individual #201) were listed as Priority 1, but had not received an assessment in the last year and were not scheduled to receive one until January 2012. Each had received at least some level of indirect communication supports via the provision of AAC. Individual #287 was identified as receiving direct therapy. Individual #7, Individual #389, Individual #90, Individual #273, Individual #310, and Individual #206 were scheduled for assessment during the month of this onsite review. Their most current assessments had been completed over 12 months ago. Approximately 87 others were due assessments in 2012 with the remaining individuals not scheduled for communication assessment until 2013. They were listed as Priority 3, 4, or 5. Some had not received an assessment in two or three years and none were current within the last 12 months. As such, the previous assessments would not likely be considered comprehensive. Another list submitted identified that only 31 individuals had been assessed since the previous review and 12 of those were newly admitted to SGSSLC. Only 17 (55%) of these had been completed prior to the individuals' PSP. Per Dena Johnston, OTR, all assessment updates were to be completed per the PSP schedule effective 11/1/11. A list identified 52 individuals with one or more AAC systems. This represented 82% of those individuals identified as nonverbal or partially verbal (Priority 1 and 2). Two individuals (Individual #190 and Individual #345) were identified as Priority 3 and one individual (Individual #209) was not included in the Master Plan. AAC devices included the following: visual timelines and schedules, communication books, Twin Talk, seven space Take and Talk, Put 'Em Arounds, social stories, scripts for specific activities, sequencers, communication dictionaries, communication boards, four space Go Talk, among others. These systems appeared to be varied, individualized, and designed to be available to individuals across environments. Only 50% of the individuals with AAC systems, however, had received a communication assessment within the last 12 months. Individual #345 had received a very brief annual review on 1/25/10 with no more current assessment provided. At that time, it was documented only that she was able to communicate her needs verbally and independently, and was not a candidate for AAC. She was listed, however, with a doorbell per the AAC list submitted, identified as a call button and chime in her PNMPs. Her most recent PNMP, dated 12/2/11, documented that this was provided in case she required assistance, especially when ready to come inside from the smoking area. It would be expected that each of the 52 individuals who had been provided AAC would receive an annual communication assessment or update. There was insufficient staffing to adequately provide needed communication supports and services. This barrier was also documented in the POI submitted.	

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R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**All individuals in need of AAC are identified as being in need of AAC.** As stated above, many individuals living at SGSSLC had not yet received a comprehensive communication assessment and, therefore, it would not be possible to determine if all individuals who required AAC had been provided those supports. As reported by the clinicians, implementation of the systems provided to approximately 52 individuals was inconsistent. Routine participation by the clinicians in day programs and home activities was limited due to staffing. It was reported, however, that the clinicians consistently now conducted their assessments in the natural environment. Communication evaluations were contained in only 16 of the records submitted, though the assessments submitted for 13 of these were not current within the last 12 months. The documents submitted also included a request for the five most current assessments for each clinician. Only 13 assessments were submitted for three clinicians. Two of these assessments had been completed prior to the previous onsite review. Only four individuals were identified who received some type of direct communication intervention. Assessments, PSPs, PSPAs, SAPs and other documentation related to this therapy were requested for each individual, though submitted for Individual #278 and Individual #287 only. Individual #278's assessment dated 7/2/10 was not current within the last 12 months and was duplicated in these requests. The assessment for Individual #128 was also duplicated in these requests. Based on the documents submitted, a total of 14 assessments were reviewed and of these, 100% (14 of 14) indicated that the individuals presented with significant communication deficits. The assessments were similar across individuals as to format and headings, and the recommendations often lacked specificity and evidence of involvement by the speech clinicians to ensure effective implementation of communication strategies. • It was of concern that the SLPs were not consistently involved in the development of SAPs for use in day programs and the homes, as well as therapist-directed interventions in the form of individual programming or group activities. • Recommendations for supports or interventions designed or directed by speech staff to promote improved communication and skill acquisition were noted for only two individuals in the sample of assessments reviewed. The current communication assessment format developed by the state and currently implemented at SGSSLC appeared comprehensive and addressed both verbal and nonverbal skills, expressive and receptive language skills, behavioral considerations, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		AAC, including effectiveness of any current systems and potential for use of other systems as identified through assessment. Per this format, the analysis of findings was intended to provide a summary of findings, interpretation of assessment results, strengths, needs, preferences and the rationale for recommendations. This would represent an appropriate analysis, but these elements were not present in any of the 14 assessments reviewed in the sample. In some cases the only analysis was that the individual presented with a significant communication disorder due to cognitive impairments or diagnoses of autism or mental retardation (Individual #111). An audit system similar to that conducted for OT/PT assessments was planned for communication assessments to ensure that the content and comprehensiveness of these was consistent across each of the clinicians, but had not yet been implemented at the time of this review. PSPs, PSPAs, assessments, SAPs and documentation related to interventions by speech clinicians were requested for the following individuals identified as currently participating in direct communication therapy (Individual #278, Individual #287, Individual #66, and Individual #265). Documentation was submitted for Individual #278 and Individual #287 only. Though the list provided indicated that direct intervention was related to communication for Individual #287, the documentation submitted was related to safe eating and promoting use of sensory tools to redirect hands in mouth behavior rather than promoting communication skills. Documentation was not submitted for Individual #66 or Individual #265. Documentation and integration of communication intervention was absent in Individual #278's PSP. His most current assessment submitted was dated 7/2/10 despite the provision of direct and indirect communication supports and services. There were no goals or objectives related to direct speech therapy in his PSP dated 5/11/11. Progress notes reflecting intervention by the speech assistant were noted on seven occasions from 6/21/11 through 11/17/11. There were no stated measurable goals related to this intervention and no training plan though per these notes the focus appeared to be related to eye gaze. The need for direct therapy was not referenced in his most current communication assessment or PSP. Additional PSP training objectives for Individual #278 included that he would choose a room at the Suzy Crawford Center to participate in by smiling (start date of 5/19/10), choose one of two movies offered by smiling (start date 6/1/11), and that he would watch the movie of his choice (start date 9/1/11). It was reported on the data sheets submitted, however, that Individual #278 already communicated via smiling when he liked or wanted something (i.e., this was not a new skill, but one that he already demonstrated). In fact, his communication assessment from 2010 indicated that staff should instead attempt to elicit yes/no responses from him using looking up for "yes" and looking down for "no" because this appeared to be a skill that showed the most	

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		potential for improvement. This, however, was not even mentioned in his PSP. Another training objective was to choose one of two movies offered by smiling. Documentation indicated that he completed this independently 12 times, required physical support 10 times and required one or two verbal prompts 21 times. It was not clear how the staff provided physical support for the smiling response or provided verbal prompts to encourage a choice by smiling. The lack of smiling may have indicated that he did not want to participate per the description on the data sheet. Clearly staff needed support and guidance for the development of appropriate communication training for Individual #278. There were approximately 62 individuals identified as Priority 1 and 2 (i.e., most likely to benefit from AAC), but only two of these individuals participated in direct communication supports (Individual #66 and Individual #278, i.e., 3%). Approximately 91% of those identified as Priority 1, 63% of those at Priority 2, and 6% of those at Priority 3 were provided some type of AAC system. The clinicians should be commended for the provision of these supports, but careful examination of the meaningfulness of the device within the individual's daily routine and/or the adequacy of supports provided to the staff to ensure implementation was still needed. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** Specific skill acquisition outcomes were outlined in two of the assessments reviewed. For example, in the case of Individual #154, three measurable goals for direct intervention to improve his communication skills were included in his speech-language evaluation dated 9/30/11. There was no evidence that this was implemented, however, because he was not identified as participating in direct speech therapy per the list submitted. In the case of Individual #150 a recommendation for direct intervention was noted in the evaluation dated 11/8/11. Specific measurable goals were not outlined in the report, though, general expected outcomes were identified. Other assessments provided active treatment suggestions and communication strategies for implementation by the PST, but there was no evidence that the speech clinicians assisted with the design of skill acquisition programs or training of staff related to their assessment recommendations.	

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		Standard: For persons receiving behavioral supports or interventions, the Facility had a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP. Communication programs are integrated into the PBSP as indicated. There was no specific screening or assessment process for those with behavioral concerns and potential need for AAC, even though the current comprehensive assessment had content areas related to behavior. There was no specific policy related to the identification of behavioral challenges and related communication deficits. Lists were requested of individuals with communication-related replacement behaviors in their PBSPs (11 individuals identified) and also for individuals who had behavioral concerns and severe communication/language deficits (28 individuals identified). The assessment used for those who had a PBSP (approximately 216 individuals, or 90% of the current census) was the same used for other individuals living at SGSSLC. Per the Master Plan, there were 175 individuals who did not have a current communication assessment and who also had PBSPs. It was estimated that many of the communication assessments/updates/reviews previously completed would not be considered comprehensive and appropriate based on a number of those submitted, particularly those dated prior to 2011. Examples included Individual #127, Individual #38, Individual #295, Individual #248, Individual #76, Individual #318, and Individual #153. A PSPA for Individual #236 dated 6/29/11 indicated that her previous assessment in February 2010 reported that she was able to independently and verbally communicate her needs and was, thus, not a candidate for AAC. She was described as speaking in complete sentences with intelligible speech. The team, however, requested another communication assessment because it did not appear to be accurate. The re-evaluation was completed on 3/15/11. At that time, it was reported that she did <u>not</u> use words to communicate and answered yes/no questions with questionable accuracy. It was of great concern to the monitoring team that the findings in these two assessments were significantly inconsistent and, as such, each of the assessments previously completed by the speech clinicians would be in question. Concerns for the quality of the communication assessments had been reported to the facility during the monitoring team's baseline review in May 2010. At that time, it was reported that, "The current evaluations were weak in format and substance and will need to be redone. This will be a monumental task and serious thought must be given to the logistics of this to ensure that the re-evaluations are thorough and accurate, and that appropriate recommendations are brought forward with timely implementation. This must be considered to be of the highest priority." Approximately 149 of the individuals listed in the Master Plan who had a PBSP had an assessment dated <u>prior</u> to this baseline	

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		visit. Only three of the individuals for whom communication assessments were submitted were identified as having behavioral issues with coexisting language deficits, though 10 of the 14 assessments reviewed by the monitoring team were listed with PBSPs. While some of the assessments made reference to a PBSP, there was often limited or no discussion of how or if limitations in communication skills contributed or exacerbated behavioral concerns. In some cases, behavioral issues were not discussed in the assessments despite that the individual was provided with a PBSP **(**Individual #251, Individual #253, and Individual #150). There were 28 individuals with PBSPs and coexisting severe language deficits included on the list submitted, though Individual #150, Individual #128, Individual #384, Individual #198, Individual #154, and Individual #111 were not listed. In other cases, communication issues that may have been related to behavioral concerns were identified, but potentially effective strategies were not integrated into the PBSP or PSP (Individual #128 and Individual #288). In fact, the use of PECS cards was identified in Individual #288's PSP, AAC was identified in his PBSP, and drawing or use of signs were identified in his communication assessment. This clearly reflected that team integration was ineffective. Substantial compliance in this area will not be achieved by merely describing the PBSP in a section of the communication assessment. Collaboration between SLPs and psychology related to assessment and analysis of associated communication and behavioral concerns, as well as in the development and implementation of related training objectives, is required. Susan Holler currently participated on the BSP Committee which was one step toward improved interdisciplinary communication in the development of communication programs, BSPs, and the coordination of their implementation via the PSP process.	
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.	**Standard: The PSP contains information regarding how the person communicates and strategies staff may utilize to enhance communication. Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.** Of the PSPs submitted for review, only two were not current within the last 12 months (Individual #198, 6/16/10 and Individual #179, 12/2/10). The PSP for Individual #76 expired on 12/10/11 during the week of this onsite review. There were: • no descriptions of expressive or receptive communication skills outlined in the PSPs for 60% of those reviewed.	Noncompliance

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		• very minimal descriptions of receptive and/or expressive communication included in the PSPs for 20% of those reviewed. • limited descriptions of receptive and/or expressive communication with limited strategies for staff use outlined in 16% of the PSPs reviewed. In only one case, was a more extensive picture of the individual's communication skills described as well as some strategies for staff use noted in the PSP (Individual #66, 3/30/11). By report, the speech clinicians had provided training to the QDDPs related to this issue on 6/8/11. The training sheet documented only that the clinician discussed the assessment schedule rather than strategies to ensure that the PSP would reflect how an individual communicated, as well as strategies for staff use. Further, it was reported that when the communication assessment was completed outside of the annual PSP, the clinicians would participate in a PSPA in order to discuss the findings and recommendations with the PST. This was not noted in any of the PSPAs submitted with the communication assessments. In the case of Individual #222, a PSPA meeting was held to review progress with communication strategies. It was reported that the picture sequencer was working effectively and was to continue for toothbrushing and then expand into foot care. A red button to notify nurses was discontinued as he did not use this device. A training objective was to be constructed by the SLP and forwarded to the PST for implementation. There was no evidence that this was done in a subsequent PSPA or Integrated Progress Notes. **Standard: Communication information is not only present in the PSP but integrated into the daily schedule** As stated above, adequate information related to communication was not present in the majority of the PSPs reviewed. Strategies for use by staff in order to be an optimal communication partner with the individuals they supported were generally absent from the PSPs reviewed. There was no staff training or assistance to develop SAPs or to provide modeling and support for effective implementation of the communication strategies recommended in the communication assessments. By report and by observation, AAC systems provided to individuals were not consistently implemented throughout the day or across settings. **Standard: AAC devices are portable and functional in a variety of settings.** The majority of systems provided were intended to be functional and many were portable for use across a variety of settings, however, these were not generally	

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		implemented throughout the day. **Standard: AAC devices are individualized and meaningful to the individual.** The systems provided appeared to be individualized and potentially meaningful to the individual. Consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual was often not possible. It was reported on the Skills Drills conducted by the PNMPCs that, in some cases, the device was in the DSP office or was otherwise not available to the individual (Individual #323, Individual #201, Individual #50). Additional findings noted in the monitoring conducted were that the individual did not use the AAC system (Individual #217, Individual #386, Individual #210, Individual #27, Individual #201, Individual #146). Evidence of intervention related to these findings was not noted. There was no mechanism to ensure that each of the strategies recommended in the assessments were effectively implemented by staff. **Standard: Staff are trained in the use of the AAC.** NEO staff training in the area of communication was largely lecture with limited opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. However, all new employees assigned to 516E/W, 509B, 508A, and 510A were to spend the morning with the QDDP and the afternoon with a PNMPC on the second day of their assignment to these homes following the classroom NEO training. The PNMPCs focused on training related to PNM issues for the individuals in that home. Per the policy revision dated 7/28/11, staff would not be included in the ratio for the home nor could they be pulled to another home during the first five days of their assignment. Communication strategies outlined in the PNMP were addressed at that time. By report, the PNMPCs had been competency-trained to conduct monitoring and training in the area of communication. An outline of this four hour training had been developed and appeared to be comprehensive. PNM Skill Drills were conducted to assess competency, and retraining and repeat drills were conducted until competency was achieved. An employee agreement was signed by the new staff acknowledging that the PNMP must be followed at all times. A PNMP Tool Ring was provided to each new staff with key elements and reminders related to aspiration, choking, diet textures and liquid consistencies, dining plan use and communicating with an individual who used AAC. Staff not deemed to be competent were not to be permitted to assist an individual alone. **Standard: Communication strategies/devices are implemented and used.** The call button and chime for Individual #345 was reported to be out of service per monitoring forms dated 9/11/11. Apparently this had not been reported by staff and	

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		was discovered by the PNMPC, though it was documented that staff understood that this should be reported. Per the monitoring form, the battery was replaced two days later. As described above AAC systems were maintained in the DSP office or were otherwise unavailable to the individual in a few cases. While the general interactions of staff with the individuals they served were generally positive, much of the interaction observed by the monitoring team was specific to a task, with little other interactions that were meaningful, such as during a meal. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology), should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Standard: Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.** The PNMP Monitoring Form and Skills Drills were used to monitor AAC. A schedule for this monitoring by the PNMPCs had been established and was based on the risk levels identified by the PSTs. There were eight PNMP monitoring sheets completed for eight individuals in October 2011. This represented monitoring that occurred in the area of communication. One of these was not completely filled out as required (Individual #194) and five others documented noncompliance with the PNMP for from one up to nine essential elements monitored. There was 100% compliance documented for only two of the PNMPs monitored (Individual #287 and Individual #134). There were 33 Skill Drill forms completed for 23 individuals to assess staff compliance. There was 100% compliance reported during the month of October 2011. Careful analysis of the findings of these different, but similar forms of monitoring was required to ensure that there are no system discrepancies and that the findings are accurate and consistent. A system of program effectiveness had been implemented which involved review of direct and indirect supports by the Rehabilitation Therapy clinicians with findings to be discussed at the monthly Rehabilitation Therapy Clinical Supports meetings. A schedule based on risk levels had been established as well. The Program Effectiveness Tracking spreadsheet (11/16/11) was submitted and included findings from September 2011 and October 2011. Monitoring was conducted for 19 individuals. Individual #331 was listed twice for the same date and Individual #211 was monitored twice in September. The	Noncompliance

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		findings on 9/8/11 (more staff training needed and meet with the PST to discuss higher tech AAC) and 9/26/11 (meet with PST to discuss higher tech AAC) for Individual #211 were similar, indicating a need to meet with the PST. The established timeline for the meeting was 11/1/11. There was no indication on the spreadsheet if this had been completed. Individual #211 had not been included in the sample of individual records so this could not be confirmed in that documentation. A note on an AAC Skills Drill conducted on 10/6/1, however, indicated that the meeting was held on 11/1/11, but the outcome of the meeting was not stated. Some of the plans were deemed effective (8/20, 40%), while others required some action or follow-up related to communication (10/20, 50%). The spreadsheet did not address completion of actions or follow-up required and it was not known if or when these were completed. The system should provide a mechanism to identify issues requiring attention by a licensed speech clinician. Similar issues were also identified by the PNMPCs, but in some cases the clinician merely indicated that the program should continue rather than follow-up to address concern (Individual #217, Individual #146, Individual #201 and Individual #111).	

Recommendations:

1. Review the current format and content of NEO staff training. Revise as indicated to ensure that the focus is for new staff to develop skills as effective communication partners. This should by interactive and dynamic with opportunities for role playing and practice (R1).

2. Review existing comprehensive assessments for those who were identified as Priority 1 and 2 to determine if these assessments met the standard as outlined per the Settlement Agreement (R2).

3. For those receiving direct services, well defined, measurable, meaningful, and functional goals or outcomes must be clearly stated with indices of progress reviewed no less than monthly. Modifications to intervention plans must be made when lack of progress is noted. Ensure all of these are integrated into the PSP process (R3).

4. PNMPs should include descriptions of expressive communication as well as strategies for use by staff (R3).

5. There is an urgent need to develop programs to address increasing or expanding language skills, ability to make requests and choices, and other basic communication skills. Formal programming is indicated for a number of individuals. Speech staff should also model more informal ways to promote interaction and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. The existing OBS program did not appear to have sufficient input and participation from professional staff to ensure that it was functional, meaningful and outcome based (R1).

6. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs (R3-R4).

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 #223, Individual #189, Individual #398, Individual #247, Individual #151, Individual #371, Individual #382, Individual #309, Individual #321, Individual #325, Individual #120, Individual #248, Individual #18, Individual #385, Individual #132, Individual #252, Individual #305, Individual #345 o Skill Acquisition Plans (SAPs) for: • Individual #189, Individual #223, Individual #398, Individual #247, Individual #151, Individual #371, Individual #382, Individual #309, Individual #55, Individual #345 o SAP data for: • Individual #55, Individual #371, Individual #345, Individual #382, Individual #309 Individual #151, Individual #247, Individual #398, Individual #223, Individual #189 o Skill Acquisition Program Training, dated 4/11 o QDDP Meeting minutes, dated 7/27/11 o Personal Focus Assessment for: • Individual #189 (8/26/11) o Functional Skills Assessment Process, undated o Training Roster for Functional Skills Assessments, dated 8/25/11 o Section S Presentation Book, undated o San Angelo Plan of Improvement, dated 11/22/11 o SGSSLC Quality Assurance Report, dated 10/11 o List of Individuals with Systematic Desensitization plans, undated o Systematic Desensitization Plans for: • Individual #261, Individual #201 o Community Outing Form, undated o List of Individuals Employed on and off Campus, undated o List of Individuals who were under age 22 and an indication of whether they were still in school and if so, which school program they attended o Minutes from SGSSLC meetings with WISD, 12/1/11 o WISD SGSSLC Memorandum of Understanding, undated draft, unsigned o WISD proposed integration plan o PSP, ARD/IEP, and progress notes from WISD for: • Individual #239, Individual #292, and Individual #6

	Interviews and Meetings Held: o Michael Davila, QDDP Coordinator; Michael Fletcher, QDDP Educator o Tammy Ponce, Active Treatment Coordinator o Gary Flores, Director of Day Programs o John Church, Associate Psychologist o Melinda Gentry, Residential Director Observations Conducted: o Observations occurred in various day programs and residences at SGSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals; 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), and • Implementation of behavior support plans o WISD classroom on SGSSLC campus
	Facility Self-Assessment: SGSSLC submitted its Plan of Improvement (POI), dated 11/22/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the facility identified what tasks have been completed and the status of each provision item. The POI did not indicate how the findings from any activities of the self-assessment were used to determine the self-rating of each provision item. SASSLC's Plan of Improvement (POI) indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas. The POI established long-term goals for compliance with each item of this provision. Because many of the items of this provision required considerable change to occur throughout the facility, and because it will likely take some time for SGSSLC to make these changes, the monitoring team recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggested that facility focus on in the next six months are summarized below, and also discussed in detail in this section of the report.

	Summary of Monitor's Assessment: This provision of the Settlement Agreement incorporates a wide variety of aspects of programming including skill acquisition, engagement in activities, and staff training. To assess compliance with 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. Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were improvements since the last review. These included: ▪ Established a skill acquisition PIT group to integrate Skill Acquisition Plans (SAPs) into day programming ▪ Inclusion of all components necessary for acquiring new skills ▪ Began the use of forward and backward chaining for the training of SAPs ▪ Plan to expand the staff who write, monitor, and implement SAPs ▪ Development of a new system to track the implementation of SAPs in the community

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SGSSLC. As indicated below there have been improvements, however, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. <u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at SGSSLC had multiple skill acquisition plans. Since the last review (May 2011), the name of these plans was changed from Specific Program Objective (SPO) to Skill Acquisition Plan (SAP). These were written and monitored by QDDPs (qualified developmental disabilities professionals). SAPs were implemented by direct care professionals (DCPs). An important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. As discussed in the last report, the facility recently modified the SAP training sheet/format to include a rationale for the SAP. The purpose of including the rationale on each SAP training sheet was to encourage staff to ensure that the plan was functional and practical for that individual. The goal was to transfer all skill acquisition plans to the new format by the end of the year.	Noncompliance

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		The monitoring team reviewed 33 SAPs that were in the new format. All of the SAPs reviewed included a rationale that stated that the individual wanted to acquire the targeted behavior. For example, Individual #189's SAP for money management included the statement that management of his money is something that was important to him. The addition of a section to the SAP training sheet that required the rationale for choosing the target skill is a direct way to ensure and document that SAPs are based on individual needs and preference. In 13 of the 33 SAPs reviewed (39%) the rationale appeared to be based on a clear need and/or preference. For example: • The rationale for Individual #382's SAP of cleaning her room was that she had sustained several injuries from tripping over items in her room. • The rationale for Individual #55's SAP of cooking was that she wanted to learn to cook (which was documented as a preference in her PSP), and being able to independently cook increased the likelihood of success in the community. In 20 of the 33 SAPs reviewed (61%), however, stated preferences (e.g., Individual #223 SAP of managing his money, Individual #55's SAP of medication management) were not clearly documented in the PSP, and no rationale for a need was presented. The monitoring team cautions the facility to avoid attempting to address the need to demonstrate that SAPs are practical and functional, by simply stating that each individual wants to acquire the targeted skill. Rather the facility should ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual. The rationale for every SAP does not have to be the individual's preference. It can also be based on a need as determined by the PST. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response	

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		• Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology This represented an area where the facility had made improvements. As discussed in the last report, SGSSLC had begun to modify the SAP training sheet to ensure that all of the above components were included. The new SAP training sheet contained a space to list specific consequences for correct and incorrect responses, and a space to discuss how to accomplish maintenance and generalization. All skill acquisition plans reviewed included all of the above components. Another area of improvement since the last review was the expansion of the training methodology at SGSSLC. At the time of the onsite review, the facility began using the Murdoch Center Foundation skill acquisition system. This system consisted of task analyses, forward and backward chaining instruction, and a self-graphing data procedure. All of the DCPs interviewed indicated that they liked the Murdoch system, and found it easier than the previous system to implement. Review of implementation, however, indicated that much more training and monitoring of SAPs at SGSSLC was necessary (see S3). The new SAP training sheets and training methodology represented potential improvements in the identification and implementation of SAPs at SGSSLC. <u>Desensitization skill acquisition</u> Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. A list of dental desensitization plans developed indicated that four plans were developed since the last onsite review. The psychology department had recently developed an assessment procedure to determine if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) was then developed. It is recommended that individualized dental desensitization plans be incorporated into the new SAP format. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail in future site visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in the last report, SGSSLC included replacement/alternative behaviors in each PBSP. As discussed in K9, the training of replacement behaviors that require the	

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		acquisition of a new skill should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. Communication and language skill acquisition The monitoring team did not encounter any acquisition programs targeting the enhancement or establishment of communication and language skills. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (also see section R). Service objective programming The facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also written and monitored by the QDDPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see provision F for a review and discussion of service objectives). Engagement in Activities As a measure of the quality of individuals' lives at SGSSLC, 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 homes at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below. As reported in the last review, the monitoring team was encouraged by the overall quality of age appropriate and typical activities at SGSSLC. Consequently, in several homes visited (e.g., 510A), many of the individuals were out of the homes, engaging in activities (e.g., playing bingo in the community, at the gym). Many of the remaining individuals were often engaged in other typical activities, such as listening to music, talking to friends, watching television, or playing video games. In home 509A, several of the individuals were involved in helping to clean the kitchen after dinner. In the homes where individuals did not possess the skills to readily engage in independent activities, the ability to maintain individuals' attention and participation in activities varied. A	

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		particularly good group activity was found in Home 502 where several individuals were actively engaged in tabletop activities. The table below documents engagement in various settings throughout the facility. The average engagement level across the facility was 71%, a considerable increase over that observed during the last two reviews (i.e., 60% and 63%). As indicated above, the monitoring team was pleased with the quality of engagement at several of the homes and day programs at SGSSLC. There were, however, some homes (e.g., 516West) were individual engagement was poor. An engagement level of 75% is a typical target in a facility like SGSSLC, indicating that the engagement of the individuals at SGSSLC continued to have some room to improve. In attempting to compare the facility's engagement data with those collected by the monitoring team, it was learned that the SGSSLC's engagement data were not being summarized or shared with the staff responsible for improving engagement. Additionally, engagement at SGSSLC was not the responsibility of any one person, but rather the responsibility of several individuals who were not necessarily aware of how other individuals were planning to improve it. It is recommended that engagement data be collected in all homes and day programs. Additionally, these data should be summarized and shared with managers responsible for improving engagement. Sites with low engagement should be identified and target engagement levels established. Finally, it is recommended that one staff person coordinate all data and efforts for improving Individual engagement across the entire facility. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
512 A	3/5	2:5
Vocational Workshop	3/5	2:5
516 East	3/7	3:7
516 West	1/4	0:4
502	2/2	1:2
502	3/5	2:5
509 A	3/3	2:3
509 A	2/2	1:2
509 B	1/1	1:1
505 A	3/10	2:10
505 A	3/7	2:7
505 B	1/1	0:1
Vocational Workshop	14/18	5:18
Vocational Workshop	13/15	6:15

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504 A	2 /8	2:9
504 B	2/5	2:5
Imagination Center	3/3	2:3
Imagination Center	4/4	1:4
Suzy Crawford Center	2/2	2:2

Educational Services

SGSSLC continued to have a good working relationship with Water Valley ISD that appeared to be benefiting the individuals who were entitled to receive educational services. Since the last onsite review, the facility's liaison to WISD had taken a promotion within DADS to another SSLC. As a result, the new residential director, Melinda Gentry, and the QDDP coordinator, Michael Davila, were, together, working with the school district. This made a lot of sense, especially given that the QDDPs are the ones who a responsible for ensuring that the PSP relates to the ARD/IEP. The QDDP for the students attended and participated in all ARD/IEP meetings. Both Ms. Gentry and Mr. Davila, however, were new to these school-related responsibilities. Therefore, they should obtain some training regarding special education laws and processes.

Nine individuals were receiving educational services. Six attended the SGSSLC on campus WISD classroom. The other three attended school at WISD. A number of students had graduated, as noted in the previous monitoring report.

Ms. Gentry and Mr. Davila reported that they were focusing on the topics noted in the previous monitoring reports. A periodic meeting was being held with the school district administration to discuss issues and keep communication open. One of the topics was for there to be more inclusion of students into classes and other activities at WISD. To that end, the school district had written an integration plan to help guide whether a student would attend school at SGSSLC or at WISD. The plan, however, did not provide guidance regarding increasing students' inclusion from their segregated classroom at WISD to the other WISD school classes and activities.

A second topic was to have school objectives be written in a measureable way, so that they could be incorporated into SGSSLC activities. Along these same lines was a goal to have progress reports be written in way so that SGSSLC staff could easily understand whether there was progress or regression. The ARD/IEPs included objectives for each of the students. The ARD/IEP for Individual #239 contained a wide variety and large number of objectives that covered many different academic and functional areas. The ARD/IEP for Individual #292, however, only had a handful of objectives. The ARD/IEP for Individual #6 was from her previous school district and, therefore, was not relevant to this review. The PSPs for these three individuals indicated that they attended school,

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		but did not incorporate anything from their school activities in any other way. In addition to doing so in the annual PSP, the WISD progress reports should be reviewed by the PST as part of the regular quarterly PSP review meeting. Third, they planned to continue to discuss extended school year services with WISD. The monitoring team observed the SGSSLC campus WISD classroom. All six students were present. The class was watching the movie Pearl Harbor and during a break, the teacher led a discussion about Pearl Harbor and World War II. Of note was that there were six adults in the classroom with the six students (WISD teacher, WISD teacher assistant, two assigned SGSSLC staff, and two assigned one to one staff). With that much staffing, the students should be engaged in a lot of educational activities with engagement and participation and good data collection. Also, as noted in the previous monitoring report, the condition of the classroom setting was poor. The rooms needed painting, decorations, and other items so that it looked more like a school and so that it might be more inviting to students.	
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.	SGSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives. Overall, however, more work is needed to achieve substantial compliance for this item. At the time of the onsite review, the facility was beginning the use of the Functional Skills Assessment (FSA) to replace the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. The monitoring team looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology) and individual preference, to identify meaningful individualized skill acquisition programs. Finally, while the PSP attempted to identify individual preferences, no evidence of systematic (i.e., experimental) preference and reinforcement assessments (when potent reinforcers or preferences are not apparent) were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance

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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	SGSSLC has made progress on this provision item. More work, however, in the areas of integrity of the implementation, and the demonstration of practicality and function of SAPs is needed (see S1). Therefore, this item was rated as being in noncompliance. At the time of the onsite review, QDDPs at SGSSLC summarized SAP data monthly and presented those data at quarterly meetings. The QDDPs graphed SAP outcome data to improve data based decisions regarding the continuation, modification, or discontinuation of SAPs. Additionally, as described in S1, the facility recently began to use a data collection system that resulted in DCPs graphing individual SAP data. Reviews of SAP data revealed that skill acquisition plans were producing meaningful behavior change for three of 33 SAPs reviewed (9%). There were no examples of SAPs modified or discontinued as a result of the absence of progress. It is recommended that the facility ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data. The monitoring team reviewed SAP data sheets to evaluate if data were completed as scheduled, and implemented with integrity. The results from those observations were mixed. For example: • Individual #247's vocational SAP included data on each step, however training was to occur on one step at a time. • Individual #371's communication SAP specified that he should progress to the next step after five consecutive sessions of independence. His data sheet, however, indicated that one step did not progress until six sessions of independence were recorded, and another progressed after only three consecutive sessions of independence. Overall review of available SAP data from the new Murdoch format indicated that 13 of 33 (39%) were not correctly implemented. On the other hand, scheduled data were present in five of five (100%) of SAP data sheets reviewed in the homes.	Noncompliance

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		These observations suggested that SAPs were being conducted as scheduled, however, it questions remained as to whether they were consistently being implemented as written. The only way to ensure that SAPs are conducted as written is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. Finally, at the time of the onsite review, the facility was planning to expand the use of SAPs to all day programs and therapy/psychoeducational classes (see K8). Additionally, the facility was planning to expand the staff responsible for writing and monitoring of SAPs. The monitoring team is very supportive of these plans, and believes they can help to address the issues of training and implementation discussed above.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SGSSLC enjoyed various recreational activities in the community. As in the last review, the facility investigated ways to document the occurrence of training in the community. At the time of the onsite review, the facility did not have data on community training, and, therefore, this item was rated as being in noncompliance. SGSSLC reported that it regularly conducted three types of training activities in the community. These activities included the training specific SAPs, training of general community skills (e.g., social skills in a restaurant), and recreational activities. It is recommended that these various training activities in community be separately recorded so that community training trends could be better tracked, and increased across the facility. At the time of the onsite review, one individual at SGSSLC worked in the community. This represented a slight increase in the number reported during the last onsite review when no individuals worked in the community.	Noncompliance

Recommendations:

1. Extend the new SAP training sheet to all SAPs throughout the facility (S1).
2. Ensure that the rationale for the selection of each individual's SAPs is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1).
3. It is recommended that dental desensitization plans be incorporated into the new SAP format (S1).
4. Alternative/replacement behaviors that require the acquisition of a new skill should be incorporated into SAPs (S1).

5. The facility should expand the number of communication SAPs for individuals with communication needs (S1).

6. Individual engagement data should be summarized and shared with managers responsible for improving engagement. Sites with low engagement levels should be identified, and target engagement levels established. Finally it is recommended that one staff person coordinate all data and efforts for improving Individual engagement across the entire facility (S1).

7. Provide training on special education laws to the residential director and QDDP coordinator (S1).

8. Engage in actions to support the inclusion of students into school classes and activities (S1).

9. Engage in actions to support extended school year services, as appropriate (S1).

10. Improve the relationship between the PSP and the ARD/IEP by:
    a. Incorporation of the IEP into the PSP, as appropriate
    b. Review of WISD progress reports and report cards during the PSP quarterly review (S1).

11. Improve the SGSSLC classroom environment, such as wall repair and painting, floor repair, and general pleasantness of the setting (S1).

12. Use systematic (i.e., experimental) preference and reinforcer assessments when potent reinforcers or preferences are not apparent (S2).

13. Ensure that data based decisions are made concerning the continuation, discontinuation, or modification of SAPs (S3).

14. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written (S3).

15. It is recommended that the various training activities in the community be separately recorded so that community training trends could be better tracked, and increased across the facility (S3).

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, and attachments o Draft new PSP format blank form o Organizational chart, undated o SGSSLC policy lists, dated 10/31/11 o List of typical meetings that occurred at SGSSLC, (incomplete) o SGSSLC POI, 11/22/11 o SGSSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/5/11 o SGSSLC facility-specific policy, Continuity of Service, most recent revision, 10/6/11 o Community Placement Report, last six months, through 12/1/11 o Job description for transition specialist (new position) o List of individuals who had been placed since last onsite review (13 individuals) o List of individuals who were referred for placement since the last review (23 individuals) o List of individuals who were referred and placed since the last review (0 individuals) o List of total active referrals (33 individuals) o List of individuals who requested placement, but weren't referred, (27 individuals) • Documentation of activities taken for those who did not have an appointed LAR (1 of 15 individuals) • List of individuals who requested placement, but weren't referred solely due to LAR preference, (12 individuals, however, this list was incomplete) o List of rescinded referrals (2 individuals) and PSPA notes regarding each rescinding o List of individuals returned to facility after community placement (2 individuals) • Documents related to one of these 2 individuals o List of individuals jailed or psychiatrically hospitalized at some point after placement (no information available) o List of individuals who have died after moving from the facility to the community since 7/1/09 (1 individual total, 0 since the last review) o List of individuals discharged following determination of ineligible for services (3 individuals) o List of individuals discharged under alternate discharge procedures and related documentation (1 individual) o Statewide one-page weekly enrollment report, October 2011 to November 2011 o One page graph of some data regarding placement department activities

	o Corrective action plan tracking sheet showing two items for this provision, undated o Email from APC regarding PST members visiting homes and day programs, 8/4/11 o Some information regarding assessment updates for CLDPs, 7/13/11 o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the individual's preference and the PST's recommendation, if any, for movement to the community o Variety of documents regarding trainings and educational opportunities for individuals, LARs, families, MRAs, and facility staff. o List of about 100 individuals and an indication of obstacles (if any) to him or her being referred/placed, undated o List of individuals who had a CLDP completed since the last review (13 individuals) o Information used by APC regarding assessment submissions for CLDP (within the CLDP) o DADS central office written feedback on CLDPs (13 individuals) o Completed statewide self-monitoring tools for section T and summary tables and graphs, three different tools (living options discussion of PSP meeting, CLDP, PMM) o PMM tracking sheet listing post move monitoring dates due and completed o PSPs and associated assessments for: • Individual #321, Individual #325, Individual #251, Individual #120, Individual #248, Individual #18, Individual #385, Individual #132, Individual #252, Individual #294, Individual #305, Individual #50, Individual #193, Individual #265, Individual #292 o CLDPs for: • Individual #276, Individual #161, Individual #307, Individual #373, Individual #197, Individual #302, Individual #105, Individual #259, Individual #172, Individual #135, Individual #359, Individual #158 o Draft CLDP for: • Individual #336 o In-process CLDPs for: • Individual #247, Individual #149, Individual #206 o Pre-move site review checklists (P) and Post move monitoring checklists (7-, 45-, 90-, and/or 120-day reviews) conducted since last onsite review for: • Individual #351: 45, 90 • Individual #84: 45, 90 • Individual #368: P, 7, 45, 90 • Individual #226: P, 7, 45, 90 • Individual #158: P, 7, 45, 90 • Individual #359: P, 7, 45, 90 • Individual #135: P, 7, 45, 90 • Individual #172: P, 7, 45, 90 • Individual #259: P, 7, 45, 90 • Individual #105: P, 7, 45, 90 • Individual #302: P, 7, 45

	• Individual #197: P, 7, 45 • Individual #373: P, 7 • Individual #307: P • Individual #161: P, 7 <u>Interviews and Meetings Held</u>: o Tim Welch, Admissions and Placement Coordinator o Denise Copeland, Post Move Monitor; James Reid, Janet Jordan, Transition Specialists o Roy Smith, Human Rights Officer, and Melissa Deere, Assistant Independent Ombudsman <u>Observations Conducted</u>: o CLDP Meeting for: • Individual #336 o PSP Meeting for: • Individual #376 o Self-advocacy meeting, 12/6/11
	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. It was updated on 11/22/11. In addition, during the onsite review, the APC reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision (other than some mention of the statewide self-monitoring tools). Instead, in the comments section of each item of the provision, the APC wrote a sentence or two about what tasks had been completed and/or the status of each provision item, usually there was an extra every month or every other month. In future POIs, to present a more complete description of the self-assessment process the facility should describe what actions it took, such as observation, interview, and review of a sample of documents. These are the types of activities taken by the monitoring team as part of this compliance review. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The APC self-rated the facility as being in substantial compliance with four provision items: T1c2, T1c3, T1d, and T1g. The monitoring team was in agreement with three of these self-ratings, though again, it was unclear from discussions with the APC and from a review of the POI how SGSSLC came to any of the self-ratings in the POI. The monitoring team did not rate T1g to be in substantial compliance. Also, for this review, T2b was not rated because an actual post move monitoring was not conducted during the week of this onsite review and, therefore, could not be observed by the monitoring team. For T4, the monitoring team rated SGSSLC as being in substantial compliance based on a review of the transition of one individual

	to another facility. The APC had self-rated the facility as NA. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps addressed only provision items T1g and T4. A full set of action plans should help SGSSLC move towards substantial compliance. The action steps should be (a) revised based upon this most recent onsite monitoring report, and (b) prioritized with target dates for each.
	Summary of Monitor's Assessment SGSSLC continued to make progress towards meeting the many items of this provision. The number of individuals who were placed was at annual rate of approximately 10 percent (13 placements in six months, census of 241) and approximately 14% of the individuals at the facility were on the active referral list (i.e., 33 individuals). This showed stable/increasing trends. Data for individuals who were hospitalized for psychiatric reasons, incarcerated, or who had run away from their community placements were not available. A detailed review/root cause analysis should be conducted for any of these or similar types of significant post-move events. A major process change was soon to be underway regarding both the PSP meeting and the PSP document. The new process should improve the PST's identification of protections, services, and supports and the inclusion of the determinations of professionals regarding community referral. SGSSLC had made some progress in trying to identify obstacles to individuals living in the most integrated setting appropriate to their needs and preferences. This was evident in each PSP and in a new spreadsheet. Although these actions demonstrated SGSSLC's desire to address obstacles, there were a number of problems. DADS will soon provide more specific direction to the APC and the facility regarding the expectations for addressing the education of individual and their LARs regarding most integrated settings. The annual provider fair was held in October 2011. Data were collected by the APC indicating that attendance by individuals and staff had increased for the last three years. It appeared, however, that SGSSLC's system for managing tours had worsened since the last review. It was less organized and the recommendations made in the previous monitoring report were not addressed. The APC attended QDDP meetings and discussed the section T requirements that impact the PSP process and the activities of the QDDPs. This was good to see and should probably become a regular part of the APC's duties, especially given the importance of the QDDPs in meeting the requirements of section T. PST members were very involved in the placement activities of the individuals who were referred. They helped choose possible providers, set up and attended visits to residences and day programs, and actively participated in supporting the individual to make the best possible choice of providers. The CLDP meeting observed by the monitoring team, however, was one of the most boring meetings observed during the week of the onsite review. Even the individual himself fell asleep during the meeting.

	The APC and the transition specialists should review the format and content of the meeting so that future meetings can be more engaging and so that the important topics can be discussed earlier in the meeting. Twelve CLDPs were reviewed along with their attachments. A variety of individuals across the entire facility were placed, extra efforts were given to those referrals that were more than 180 days old, and PST participation was strong. Unfortunately, there was insufficient attention paid to individuals' past histories, and recent and current behavioral and psychiatric problems, and there was, again, an overall failure to capture what was important to the individual. There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success, even though these were indicated as being important to many of the individuals. Jobs for individuals remained an issue. Post move monitoring was conducted regularly and for all individuals, as required. This was a major feat for the PMM, especially given that individuals were placed all over the state. Moreover, she visited both the day and residential sites, and conducted the post monitoring visits at whatever time made the most sense based on the individual and his or her schedule. As a result, reviews sometimes occurred over two consecutive days, and/or in the late evenings. The areas in need of improvement were the format of the new post move monitoring tool, and the need for more active follow-up by the PMM when there were problems with supports and/or the overall placement of the individual.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably	SGSSLC continued to make progress towards meeting the many items of this provision. The admissions and placement department staff engaged in a number of activities to encourage and assist individuals to move to the most integrated setting. Tim Welch was the Admissions and Placement Coordinator (APC). He was assisted by Denise Copeland, the post move monitor (PMM), and two transition specialists who had begun their work since the last review. Thus, the placement department consisted of four full time staff. Mr. Welch reported that the PMM was to conduct all of the post-move monitoring (all over the state, as needed), and the two transition specialists were to focus on supporting and helping individuals and PSTs through the placement process once they were referred. The specific numbers of individuals who were placed was at annual rate of approximately 10 percent (13 placements in six months, census of 241) and approximately 14% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 13 individuals were placed in the community since the last onsite review. This	Noncompliance

	accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	compared with 10, 10, and 17 individuals who had been placed during the periods preceding the previous three reviews (the 17 were place during a 10-month period). o This demonstrated a stable trend. • 23 individuals were referred for placement since the last onsite review. o 0 of these 23 individuals were both referred and placed since the last onsite review. • 33 individuals were on the active referral list. This compared with 27, 21, and 19 individuals at the time of the previous three reviews. o This was an increasing number and may indicate more referrals being made by the PSTs. • 27 individuals were described as having requested placement, but were not referred. This compared with 21, 44, and 80 individuals at the time of the previous three reviews. o 12 were not referred due to LAR preference. o 7 were not referred due to the MRA not being present. This should be fixed immediately. This was noted as a problem in the previous two reports. o 5 were not referred due to legal reasons. o 3 were not referred due to what SGSSLC called behavior/psychiatric issues. Of these, a review process (called a lack of consensus review) was held only for 1 (Individual #153). A review should be held for the other 2 individuals, as well as for the 5 individuals who were not referred for legal reasons. This was given as a recommendation in the previous report. • The list of individuals not being referred solely due to LAR preference contained the same 12 individuals listed immediately above (compared to 5 and 8 individuals at the time of the previous two reviews). There were, however, likely many other individuals at the facility (e.g., those who did not or could not make a request themselves) who were not referred solely due to LAR preference. o The data for this listing needs to be corrected. This was noted in the previous monitoring report, please see the previous report for details. • The referrals of 2 individuals were rescinded since the last review. This compared to 3, 5, and 4 at the time of the previous three reviews review. o Each individual's PST met and a PSPA report was issued that provided information indicating that the decision to rescind was reasonable. One was rescinded due to serious medical and nursing needs, and one due to psychiatric instability. o The APC should do a detailed review (i.e., root cause analysis) of each of these rescinded cases to determine if anything different could have been	

		done during the time the individual was an active referral. Note that the PSPA provided a lot of detail regarding the PST's decision to rescind. The purpose of the APC review is to assess the referral and placement processes. o Note that 2 of the individuals on the active list of referrals had their referrals rescinded at the time of the last onsite review. Since then, they had been re-referred for placement. • 2 individuals were returned to the facility after community placement. This compared with 0 and 1 individuals at the time of the previous two reviews. o One of the individuals had recently returned to the facility due to behavioral problems. The APC planned to conduct a special review. A detailed review (i.e., root cause analysis) should generate recommendations that relate to the admissions and placement system at SGSSLC rather than solely for future services for the individual. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, or who had run away from their community placements were not available. A detailed review/root cause analysis should be conducted for any of these or similar types of significant post-move events. At this time, it was conducted for rescinded referrals and returns to the facility, but not for these other events. • 0 individuals had died since being placed since the last onsite review. • 1 individual was discharged under alternate discharge procedures (see section T4 below). Each of the above 10 bullets should be graphed separately and SGSSLC had started to do so since the last review. A one-page graph was presented to the monitoring team. It contained 8 sets of data, but they were graphed incorrectly. Instead, a separate line graph for each set of data should be created. Further, many of the numbers in the data table and on the graph did not correspond with the numbers given to the monitoring team over some of the previous onsite reviews. Some of this may be due to differences in time periods, but many indicate greater discrepancies (e.g., number of individuals who have died after placement). These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). <u>Determinations of professionals</u> This provision item requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. This is an activity that should occur during the annual PSP assessment process, during the annual PSP meeting, and be documented in the written PSP. SGSSLC had not made progress in this area, however, statewide plans to do so via a	

		revised and updated PSP process had not yet occurred at SGSSLC. The new process will require that professionals state their determination in their annual assessments. The determinations of professionals are to then be discussed at the annual PSP meeting and documented in the finalized PSP document. The only assessments in which any indication of professional determination was evident were in the nursing assessments for some of the individuals. In these assessments, in a section called community integration, the nurse provided his or her professional determination/opinion regarding whether the individual could live in a more integrated setting and whether or not he or she believed that needed services could be provided in the community. In some cases, the nurse did not believe that services were available or could be provided in the community. There was no indication that a discussion of the nurse's (or any other professional's) opinions were discussed during the PSP meeting or documented in the written PSP. <u>Preferences of individuals</u> SGSSLC appeared to work to honor the preferences of individuals. This was seen during PSP meetings, self-advocacy activities, and in the actions of the rights officer and assistant independent ombudsman. <u>Preferences of LARs and family members</u> SGSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. <u>Senior management</u> The APC continued to complete a statewide weekly enrollment report. This contained data for statewide office. The APC also led the weekly admission and transfer meeting, however, that focused more so on new admissions and inter- and intra-facility transfers. Some data were presented at the QI Council and in the QA report, however, these occurred quarterly and monthly, respectively. Thus, there was no mechanism to provide the kind of detail that senior management should have regarding the status of individuals who were on the referral list. This should be improved. This was recommended in the previous monitoring report.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies,	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state policy regarding most integrated setting practices was numbered 018.1, dated 3/31/10. A revision was being developed over the past months and was expected to be disseminated soon. There was a facility-specific policy related to this provision. It was called Continuity of Service. It was written in 2004 and had many revisions since then, most recently on	Noncompliance

	procedures, and practices shall require that:	10/6/11. It is likely that once the state policy is officially disseminated, changes may be necessary to this facility-specific policy and/or additional facility-specific policies may need to be developed. Any facility-specific policies should be subjected to the state office process described in V2 below, including the training of all relevant staff on any policies.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	DADS and the SSLCs were embarking on another revision to the PSP process. This was the third (or so) revision to the process since the initiation of the Settlement Agreement, however, this was not unexpected because revisions to such a major part of service provision often require repeated revisions, modifications, or even overhauls. The monitoring team wishes to acknowledge DADS' efforts to continue to work to improve the PSP process so that it meets the needs of the individuals while continuing to progress towards meeting substantial compliance with the Settlement Agreement. To this end, DADS recently brought in three consultants to work on developing a new PSP format, new expectations, and updated training for staff. The consultants will learn about the current system, develop a new PSP document format, revise the way the meeting is conducted, and provide training to staff. Moreover, the consultants were working with the DADS central office coordinator of most integrated setting practices to ensure that the many requirements of provision T would be addressed. To briefly summarize, there will be a new PSP meeting format, and a new PSP written document format. All relevant staff are to receive training. New procedures are to be modeled by the consultant, followed by observation, coaching, and corrective feedback during both mock and actual PSP meetings led by QDDPs. Overall, the new PSP is designed to address the many items that are required by the Settlement Agreement, ICFMR regulations, and DADS central office. Further, the consultants planned to include items that had been missing from previous PSP formats, such as professional's opinions, and the identification of obstacles. Unfortunately, the new PSP process had not yet come to SGSSLC. Thus, the PSP meetings, assessments, and written PSP documents were in what was now the old-style. <u>Protections, Services, and Supports</u> Given that this major process change was soon to be underway regarding both the PSP meeting and the PSP document, the monitoring team will not provide detailed commentary on the PST's identification of protections, services, and supports at this time because there was not yet a set of new PSPs for review or to observe. Some general comments on SGSSLC's PSPs, however, are provided below. Other comments regarding the facility's PSPs are provided in most sections of this monitoring report, particularly in sections F and S:	Noncompliance

		• Overall, the comments provided in this same section of the previous monitoring report (T1b1) continued to apply (see pages 366-367), including variability in length, content, and depth of information across PSPs; and absence of training objectives related to community living, especially for those individuals who were referred or likely to be referred • During the PSP meeting for Individual #376 that was observed by the monitoring team, there was extensive discussion regarding his preferences, activity participation, various needs, behavioral challenges, psychiatric diagnoses and medications, and medical conditions and possible treatments. The topic of living in the community again (he had a failed placement one year ago) came up a number of times during the meeting. The high level of active participation by PST members will likely set the stage for successful implementation of the upcoming new PSP process. <u>Obstacles to Movement</u> SGSSLC had made some progress in trying to identify obstacles to individuals living in the most integrated setting appropriate to their needs and preferences. This was evident in a paragraph in each PSP in which the PST attempted to identify obstacles. It was also evident in a new spreadsheet that listed information about the obstacles for about 100 individuals. If the obstacle was the preference of the individual and/or LAR, a reason was also included on the spreadsheet. Although these actions demonstrated SGSSLC's desire to meet this aspect of this provision item, there were a number of problems: • Not all individuals were included. • There was often more than one obstacle listed in the PSP, but only one obstacle was written in the spreadsheet for all but four of the 100 or so individuals. • LAR reluctance was listed for about 20 of these 100 or so individuals, but the data presented to the monitoring team indicated that there were 12 individuals at the facility who were not referred due to LAR preference. Thus, there was a disconnect in the data that should be resolved. • The spreadsheet contained some individuals for whom it said "no obstacles," but who were not referred. There were other individuals on the spreadsheet who had been referred and for whom there were obstacles listed. o It may be that PSTs will need to differentiate between obstacles/reasons to making a referral, and obstacles to making the placement occur. As indicated in T1g below, the state will be requiring the PST to specifically identify obstacles to placement by choosing from 12 different categories. It may be that use of this list will help PSTs to be more successful in identifying and addressing obstacles. The identifying and addressing of obstacles on an individual basis, as required by this provision item, were part of the upcoming new style PSP meeting and PSP document and,	

		as such, were undergoing major changes. The APC should also see section F1e of this report for additional information relevant to this provision item.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The monitoring teams and DADS central office recently agreed on the specific criterion for this provision item. The monitoring team expects that DADS will soon provide more specific direction to the APC and the facility regarding the expectations for achieving substantial compliance. SGSSLC was already engaging in some, but not yet all, of these actions towards educating individuals and their family members and LARs. SGSSLC's actions are described below. The current PSP template required a comment about the education of the individual and LAR. Some PSPs described what the individual had done, whereas others described what the individual might do during the upcoming year. • As noted in the previous report, the next step is for the PST to specifically report on (a) the activities of the previous year and (b) make a plan for the upcoming year. The new PSP format included a series of questions for the PST regarding these two aspects of education. o Many of the PSPs included action plans that seemed to be related to community placement. The education section of the PSP should provide some detail as to the purpose of these action plans. • The quality of the discussion regarding referral needs to improve. Detailed examples are provided in section F1e of this report. The annual provider fair was held in October 2011. Data were collected by the APC. Data indicated that attendance by individuals and staff had increased for the three years of data available. On the other hand, no family members, LARs, or staff from the MRA/LAs attended. Five providers attended, the same as last year. The APC implemented a survey for attendees. It appeared that useful information was gathered that should be used for planning purposes for next year. Tours of community providers are an important aspect of educating many (but not all) individuals about community options. The only information given to the monitoring team was a list of community tours. There were nine since the time of the last onsite review. The number of tours remained the same since the time of the last two onsite reviews. Based on the information presented, it appeared that SGSSLC's system for managing tours had worsened since the last review, that is, it was less organized and the recommendations made in the previous monitoring report were not addressed. SGSSLC had begun to take advantage of the monthly self-advocacy meeting to discuss community living. The members of the group were interested and when presented with	Noncompliance

		the option of having this as a topic, they readily voted for it. With the help of the APC and rights officer, the most recent meeting was attended by three former residents who now lived in the community. They spoke briefly about their homes and jobs. An email from the APC indicated that he hoped to make this a monthly occurrence. An annual inservice session by and for the local MRA/LAs was conducted. The agenda included items relevant to the referral, placement, and CLDP processes. Survey forms were completed by the 16 attendees. The APC reported that the facility and the local MRA/LA had a very good relationship. The APC attended QDDP meetings in June 2001, August 2011, and September 2011 and discussed the section T requirements that impact the PSP process and the activities of the QDDPs. This was good to see and should probably become a regular part of the APC's duties, especially given the importance of the QDDPs in meeting the requirements of section T.	
	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. The facility reported that individuals were assessed during the living options discussion at the annual PSP meeting, or at any other time if requested by the individual, LAR, or PST member. In addition, a listing was given to the monitoring team showing every individual, his or her preference, and whether the PST referred the individual for placement. The monitoring teams have been discussing this provision item at length with DADS, especially regarding whether the determinations of professionals in their discipline-specific assessments, a well-conducted living options discussion, and similarly well-done documentation in the written PSP, would meet the requirements for this provision item. This question will be resolved by the time of the next onsite review at SGSSLC.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in	As noted in section T1b above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Twelve CLDPs were reviewed by the monitoring team. <u>Timeliness</u>: Many of the CLDPs did not appear to have been developed in a timely manner. Many of the individuals were referred six months to a year ago, and there were often many months of apparent no activity. On the other hand, it was good to see that SGSSLC had focused on placing individuals who had been referred for such a long period	Noncompliance

	a timely manner. Such a plan shall:	of time (i.e., more than 180 days). As a result, many had been placed. It also appeared likely that CLDPs would be developed in a more timely manner in the future because there were now additional staff in the admissions and placement department. Initiation of the CLDP: Rather than waiting until right before the individual moved, the CLDP document was to be created at the time of referral with an expectation that its contents would be developed and completed over the months during which referral and placement activities occurred. The APC, the transition specialists, and the QDDPs were the primary writers of the CLDP. This process had only just begun. Three of these in-process CLDPs were reviewed and, as somewhat expected, the amount of information corresponded with the length of time since the individual had been referred. At SGSSLC, the CLDP should be started at the meeting following referral, which was called the APC-PMM-PST post-referral meeting. PST member participation: PST members were very involved in the placement activities of the individuals who were referred. They helped choose possible providers, set up and attend visits to residences and day programs (also as per an APC 8/4/11 email), and actively participated in supporting the individual to make the best possible choice of providers. As a result, the process of choosing and determining a provider were individualized. Some examples and comments are below: • Individuals went on many overnight visits to providers and to day programs. Some visits were a week long. In some cases, the individual went from provider to provider over the course of a week or two, especially if the providers were located far from SGSSLC (e.g., Houston, Dallas, El Paso). PSTs appeared to consider each individual's needs and learning style in setting up these visits. • For one individual (Individual #172), the PST and APC noted that 68 possible providers were contacted. The individual ended up visiting seven homes across three different providers. This showed that the PST and APC worked hard to find a provider. (It also indicated that the individual was very hard to place. Not surprisingly, he had many difficulties following placement that might have been better predicted with better planning during the CLDP process, see comments below.) • The PST supported individuals in choosing a provider when the choice was unclear because all the providers were acceptable (e.g., Individual #259, Individual #307) as well as when the choice was very clear (e.g., Individual #302). • The PST and APC supported a variety of types of placements, including the individual moving to live with her elderly mother (Individual #373), moving into an apartment (Individual #105), or moving a far distance from SGSSLC (Individual #161). • PSTs intervened when a provider being considered turned out to be a poor choice, such as when providers planned to place the individual in a home near a	

		children's park and failed to have the proper specialized therapists available (Individual #172, Individual #276). Even so, the transition planning and placement process will need improvement as described throughout the sections T1c1 and T1e. Post post-move monitoring PST meetings: PST meetings were only beginning to occur after every post move monitoring visit. These were reported to being run by the transition specialists. CLDP meeting prior to move: CLDP meetings should be as efficient and useful as possible. The monitoring team observed the CLDP meeting for Individual #336. The CLDP meeting is to discuss the details of one of the most exciting times for any individual at SGSSLC, that is, preparing to move to the community, to a home of his or her choice. This CLDP meeting, however, was one of the most boring meetings attended by the monitoring team during the week of the onsite review. Even the individual himself fell asleep during the meeting. The APC and the transition specialists should review the format and content of the meeting so that future meetings can be more engaging and so that the important topics can be discussed earlier in the meeting. For example, the discussion of essential and nonessential supports is probably the most important part of the CLDP and the CLDP meeting. At this meeting it did not occur until the second hour of the meeting. The meeting in total lasted more than two and a half hours. This is not, however, to say that important information was not addressed by the transition specialist who led the meeting. For example, Individual #336 was somewhat concerned about leaving (e.g., "I'll really miss this place" "What if it doesn't work out?"). The transition specialist and other staff told him that they'd all look for other places, but that they had planned for this move and should give it a try. He agreed. Another issue that came up was that no PST member had seen this home (due to the logistics of him visiting multiple providers). That was important and they decided to have the local MRA there do a visit and report back to the team. During the meeting, the monitoring team raised questions about the many inservices that were included on the list of transition activities, such as who was to be trained, what topics would be covered, and how would they determine whether staff were competent enough. The monitoring team also asked the PST to consider how they could ensure that implementation occurred once staff were competently inserviced (e.g., via a specialized daily check off sheet for staff). The new provider was on the phone (because they were in another part of the state). The monitoring team wishes to acknowledge the community provider's complete flexibility and willingness to do whatever the PST asked (e.g., data collection, activities,	

		supports). The monitoring team has found community providers to be extremely receptive to PST requests for actions, activities, training objectives, and so forth.	
	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.	Twelve completed CLDPs were reviewed by the monitoring team. The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the MRA and community provider. Implementation of the new CLDP policy, utilization of QA processes, and greater involvement of the PST will likely bring the facility closer to substantial compliance with this provision item. Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. They did not define: o Which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), and/or what level of mastery of the information was required (e.g., classroom training, demonstration of competence). o The method of training, such as community provider staff shadowing facility staff, and/or showing competency in actually implementing a plan, such as a PBSP, nursing care plans, etc. ▪ The only ENE support that mentioned competency in training was for Individual #302, for his orthotics. • Actual implementation of these supports by staff should be required in the essential and nonessential support sections, not only inservicing. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • Also see comments in T1e below. DADS central office conducted reviews of each of SGSSLC's CDLPs. The monitoring team reviewed these comments. The comments addressed all aspects of the CLDP, were excellent, and should continue. The number of needed corrections was high. In addition to making corrections to each individual's CLDP, the APC and transition specialists should try to generalize these reviewers' findings to new CLDPs so that the quality of the CLDPs will be higher (i.e., fewer problems identified by the reviewers and fewer corrections needed). • It was unclear as to whether the APC responded to the many questions, comments, and suggestions in the reviews. Therefore, the APC and transition specialists should document their response to each item in the review. This documentation should also indicate whether the draft CLDP was edited as a result of the comment. This is an important component of the process of improving the quality of the CLDPs. • Further, state office should consider developing a metric to determine if facilities	Noncompliance

		are making progress, that is, whether the feedback from state office is helping to reduce errors and improve content of the CLDPs. This is important to do because changes in the training and supervision of APCs will likely be required if no progress continues to be made regarding these important aspects of the CLDP, especially those regarding assessments and essential/nonessential supports.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities and the timelines for these actions. This included the day of move activities, ENE supports, and other pre- and post-move activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDPs contained evidence of individual review and LAR review. This was also evident during observation of the CLDP meeting.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	In preparation for the CLDP meeting, assessments were to be updated and summarized. Therefore, the CLDP document was to contain these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. The monitoring team's review of the 12 CLDPs indicated that the sets of assessments of all were, for the most part, within 45 days prior to the individual leaving the facility. The quality and content of the assessments, however, needed improvement as detailed in section F1c. In order for SGSSLC to maintain substantial compliance with this provision item, the quality of PST assessments will need to improve.	Substantial Compliance
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-	Twelve CLDPs were reviewed along with their attachments, typically assessments, PSPA meetings, and PSPs. There were a number of good actions evident, and some are noted below: • A variety of individuals across the entire facility were placed. • Extra efforts were given to those referrals that were more than 180 days old. • PST participation was strong (see T1c above). • The day-of-move list was a good idea. • Some inservice ENEs included some detail of what topics were to be covered. • There were some examples of ENE supports that were individualized: o There was an ENE support regarding how to prompt Individual #135 successfully.	Noncompliance

	essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	- There was an ENE support for the monitoring of TV viewing for Individual #172. - Individual #302 had ENE supports for social skills, problem solving, and coping. These were good and unique ENE supports (but, unfortunately, they were never defined or specified). - Individual #259's CLDP had a longer, more individualized, list of ENE supports than any other CLDP reviewed. Even so, there were lots of items that were unclear, such as something called a special needs check sheet for his dining plan. Overall, however, very little (though some) progress was made on this most important part of the CLDP, that is, the identification and definition of essential and nonessential supports (ENE). Even though there were some good examples of some supports in some CLDPs (above), more progress was expected given the findings and feedback provided in the previous three monitoring reports. The monitoring team had the opportunity to discuss this issue at great length with the APC, the transition specialists, and the PMM during the week of this onsite review. This discussion included a detailed review of the ENE support examples that the monitoring team presented in the previous report. Below are comments that applied to the set of 12 SGSSLC CLDPs reviewed by the monitoring team: - There was insufficient attention paid to individuals' past histories, and recent and current behavioral and psychiatric problems. In other words, these issues were not taken seriously enough by the PST, providers did not appear to be adequately prepared, and, as a result, the individual and provider were more likely to have an unsuccessful placement. This was evident in a number of placements where, even though the individual might not have had to return to the facility, there were problem behaviors and dissatisfaction, much of which should not have been unexpected given the individuals' histories. The monitoring team realizes that SGSSLC was placing individuals who had histories of seriously challenging behaviors and that not every placement will be successful. The facility, however, needs to take a close look at this issue (i.e., failing to address past, recent, and current problems) and address it. Further, the APC needs to treat problems in placement as needing a substantial review, such as a root cause analysis, not to point blame, but to learn, so that future transition planning can be better. For example: - Individual #302's CLDP indicated in two places that there was risk of him inflicting substantial harm on others. Further, he had a problem behavior while on the three-day trial visit. None of this was explicitly addressed in the CLDP. - Individual #172 demonstrated relationship activities that were of concern as well as possible pre-offending behavior (grooming) only a	

		month before his move. This was not addressed at all. o Individual #197 demonstrated a variety of problems in her history, related to social relationships, attention-maintained self-injury, and other significant psychiatric issues. Some of this was evident during her choosing of a provider. Moreover, she exhibited self-injurious and suicidal behaviors very close to the time of her move. None of this was explicitly addressed in the CLDP process. o Individual #373 moved in with her elderly mother. There was no indication of the expectation of the HCS provider for this potentially challenging family care situation. She had already put on a large amount of weight during the trial visits, but this was not addressed. • There was, again, an overall failure to capture what was important to the individual. This should be one of the first steps in developing the list of ENE supports. Then, each ENE support needs to be defined in observable terms, and there needs to be thoughtful consideration of what the PMM needs to observe to indicate that the support was in place. o This was discussed in detail in the previous monitoring report. The APC and transition specialists should be sure to review the personal preferences part of the CLDP and the PFA part of the PSP. • Jobs remained an issue, as discussed in the previous monitoring report. Many individuals appeared to be stuck in boring day habilitation programs when they had the capability, and desire, to be working. The facility did not appear to be doing much to address this during the transition process. • Many ENE supports were for inservices. Inservices are important, but the CLDP needs to indicate implementation after inservicing. To that end, there were many ENE supports that said things like "continue BSP." This was good to see, but the CLDP didn't provide detail about what it was that was supposed to continued, such as the aspects of the BSP, PNMP, dining plan, medical procedures, communication programming that would be important for community provider staff to do every day. There should also be a requirement for staff to document this implementation every day. This is reasonable for the PST to request of a provider, and providers have been receptive, if not desirous, of having this guidance and expectation. • There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success, even though these were indicated as being important to many of the individuals. Problems with the (a) identification, (b) definition, and (c) specification for monitoring of ENE supports were detailed in previous reports and were discussed at length during this onsite review. Further, as noted in T1c above, DADS central office commented on ENE supports in their reviews of SGSSLC's CLDPs. Thus, the facility had received frequent, detailed, and consistent feedback regarding the development of an appropriate list of	

		ENE supports from the monitoring team and from DADS central office. Below, monitoring team comments on some of the ENE supports are provided. Individual #172: • Repeatedly in his CLDP, it was noted that he needed a highly structured environment, and to work and keep busy. This was not addressed specifically and explicitly in the list of ENE supports. • Reinforcement was noted as a strong motivator, but it was not specified in the list of ENE supports. Individual #105: • The CLDP indicated that he liked to do a lot of things, but none were reflected in his list of ENE supports. • He was reported to be a loner and that being alone might lead to psychiatric problems. There was nothing related to PST discussion of how living in an apartment might contribute to him being more isolated. Individual #302: • His CLDP indicated "high risk of harm" and "risk of inflicting substantial harm," but there was nothing to indicate special considerations for the provider, other than perhaps, the ENE for one to one staffing. Individual #161: • She had a complex psychiatric medication profile and a history of medication refusals that were not addressed. • Praise and recognition were important to her, but were not indicated in the ENE supports. • She wanted to learn to cook. Cooking <u>was</u> included in her list of ENE supports. Individual #359: • She had a history of serious behavioral outbursts, including threatening the use of a knife, but this was not explicitly addressed in the CLDP. • A job was very important to her, but was not addressed in the CLDP, other than to for there to be some sort of job assessment. Individual #135: • She had a history of serious behavioral problems, including physical aggression, inappropriate sexual behavior, leaving supervision, making unfounded allegations, and refusing to attend counseling sessions. This was a concerning list of behaviors that was not explicitly and adequately addressed in the CLDP. • She wanted to read and write better, but these were not included as ENE	

		supports. This provision item also requires that essential supports that are identified are in place on the day of the move. For each of the individuals, the pre-move site review was conducted by the PMM and indicated that each essential support was in place.	
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.	DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. These reviewed the living options discussion at the annual PSP meeting, the CLDP document, and the post move monitoring documents. At SGSSLC, the forms were completed by the APC and/or the QA staff. The APC correctly identified problems in interobserver agreement and had worked with the QA staff member regarding the definitions and criteria for scoring of these forms. The monitoring team recommends that the APC take a close look at all three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of self-monitoring are adequate, and that the criterion for scoring is valid. Since the last onsite review, the APC began to collect and graph some data from his department's activities. The APC was at the initial stages of developing these graphs and, although improvements were needed (and were discussed with the APC and were noted in T1a above), it was a very good initial effort.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to	SGSSLC was beginning to gather relevant information regarding obstacles across the facility, however, was not yet analyzing information related to identified obstacles to individuals' movement to more integrated settings. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. The proposed statewide obstacles report was described in the previous monitoring report. As of the time of this onsite review, it had not yet been issued.	Noncompliance

	their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to	The monitoring team was given a document titled "Community Placement Report." It was for the previous six months, through 12/1/11. Although not yet included, the facility and state's intention was to include, in future Community Placement Reports, a list of those individuals who would be referred by the PST except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral.	Substantial Compliance

	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.	SGSSLC demonstrated continued progress towards achieving substantial compliance with this provision item. The primary areas in need of improvement were the format of the new post move monitoring tool, and the need for more active follow-up by the PMM when there were problems with supports and/or the overall placement of the individual. Timeliness of Visits: Since the last onsite review, 41 post move monitorings were called for and all 41 (100%) occurred. Of these 41, 40 (98%) occurred within the required timelines of 7-, 45-, and 90-day intervals. This was a major feat for the PMM, especially given that individuals were placed all over the state. Moreover, she visited both the day and residential sites, and conducted the post monitoring visits at whatever time made the most sense based on the individual and his or her schedule. As a result, reviews sometimes occurred over two consecutive days, and/or in the late evenings, such as at 8 p.m. Content of Review Tool: Of the 41 post move monitorings, the completed review tools for 34 (83%) were reviewed by the monitoring team. The more recent tools were completed on what was now the new format. The new format had many improvements over the previous version. These are worth pointing out here: • Explicit yes/no indication regarding the presence of each ENE support • Indication of what evidence the CLDP required be reviewed and what evidence the PMM actually did review • Eight sets of additional standardized relevant questions • Report of the LAR/family member's satisfaction • Report of the individual's satisfaction On the other hand, the monitoring team was disturbed by the loss of narrative information that was evident in every one of the old style forms. That is, in the old format, the PMM wrote a brief objective description of her findings for each of the ENE supports (a couple of sentences) as well as an overall summary of the post move monitoring, including important subjective impressions, at the end of the form (a couple of paragraphs). These sentences and paragraphs made for easy reading and were very useful in understanding the post move monitoring visit and the overall experience of the individual in his or her new day and home environments (as also noted in the previous monitoring report). This appears to have been lost in the new form and should be re-visited by state office. It is likely that the PMMs at all of the facilities would agree with	Noncompliance

		this observation and could contribute to addressing it. A lot of documentation was obtained and reviewed by the PMM, including schedules, daily observation notes, and medical appointment documents. This further indicated the comprehensiveness of the PMM's reviews. The community providers usually provided documentation regarding inservice training. In some cases, the topics covered were listed on the staff sign in sheets. More detail regarding how training occurred and how competency was assured should be included and assessed by the PMM (see T1c). Similarly, how implementation was assured by the provider and assessed by the PMM should also be included (see T1e). Sometimes, the PMM indicated efforts to this end, such as observing during a mealtime or noting that she looked at a chart or service delivery logs. One review referred to a special needs sheet. All of these need to be better described. <u>Use of Best Efforts to Ensure Supports Are Implemented:</u> PSTs and the APC and his staff put a lot of effort into these placements. As a result, the placements of a number of the individuals appeared to be very successful (e.g., Individual #359). Even so, it was disheartening that quite a number of problems occurred for many individuals after placement. These problems included behavior outbursts, psychiatric symptoms, and individual dissatisfaction. Consequently, many individuals were moved from home to home within their current provider or, in some cases, returned back to SGSSLC. The monitoring team noted above that all of these cases should receive a thorough review by the APC. Moreover, and more directly related to this provision item, it appeared, based on the monitoring team's review of post move monitoring reports, CLDPs, and other attached documentation, that the PMM should have taken more assertive action after identifying these problems. The seriousness of issues about problems, risks to current placements, and potential for additional problems were not apparent when reading the post move monitoring reports. The PMM, according to the requirements of this provision item, must do more than inform PST, she must work with APC to be persistent in getting problems addressed. Examples of problems were: • Placement risks (e.g., Individual #172, Individual #197, Individual #302, Individual #158) • Community staff not following PST and provider's restriction on number of alcoholic drinks while out at a nightclub (Individual #197) • Movement from home to home with the same provider • Lack of employment options, boredom at day program (e.g., Individual #351). This problem was noted in the previous monitoring report. PST meetings were beginning to be held following every post move monitoring visit.	

		They were to be conducted by the transition specialists. These meetings are an important part of the post move monitoring process. If the PMM can bring these issues forward, problems, such as those listed above, might be more actively addressed. Also, an option that the PST and PMM should consider is to continue monitoring past 90 days. One example of a PST meeting that did occur was for Individual #84. His PST met at around the time of his 45-day review.	
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 was unable to accompany the PMM on a post move monitoring visit during the week of the onsite review. This was due to the timelines required for post move monitoring for the individuals who lived within a reasonable driving distance from the facility.	Not Rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	

T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	One individual was reported to have been discharged under this T4 provision. It was done so properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team. The individual and the reason for discharge are below: • Individual #198: discharged to another SSLC based upon request of her family to be in a facility closer to where they lived. .	Substantial Compliance

Recommendations:

1. Quickly address those cases when an individual was not referred solely because the MRA staff person was not present at the PSP meeting (T1a).
2. Review the process for those who requested placement, but were not referred (be it for legal reasons or for behavior/psychiatric reasons) (T1a).

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

4. Collect data, and conduct a detailed review, such as a root cause analysis, for any failed or problematic outcomes of the placement process, such as rescinded referrals, post placement psychiatric hospitalization or death, returns to the facility, movement to new homes within the same community provider or to a new provider, and so forth. These reviews should be aimed at improving the referral and placement processes (T1a, T1e).

5. Do a proper line graph of the data in T1a (T1a, T1f).

6. Implement the new PSP process. This should help address the need to include professionals' determinations, properly identify and address needed protections, services, and supports, and properly identify and address obstacles to referral and/or placement (T1a, T1b1).

7. Keep senior management better informed about what's going on with individuals who are on the referral list (T1a).

8. Update facility policies to make them in line with the new state policy, and subject the facility-specific policies to the requirements of section V2 (T1b).

9. Follow state guidance on addressing T1b2, including a plan for education for each individual (T1b2).

10. Improve the system of managing tours of community providers (T1b2).

11. Start the CLDP at the post-referral meeting, the APC-PMM-PST meeting (T1c).

12. Improve the CLDP meeting (T1c).

13. Better describe the requirements for staff training and provider preparation for transitions (T1c1).

14. In the CLDPs, include the requirement for implementation rather than solely inservicing (T1c1, T1e).

15. Document APC responses to DADS state office reviewer comments on CLDPs (T1c1).

16. DADS should consider doing CLDP reviews at various stages of CLDP development, not only the version that is drafted immediately prior to the move date. In addition, consider creating a metric to measure the quality of the CLDPs (T1c1).

17. Identify and describe ENE supports better. Ensure that the most important aspects of an individual's history are addressed in the CLDP, as well as his or her preferences, needed supports, and safety (T1e).

18. Assess instructions, content, and scoring criterion for the three self-assessment tools being used for this provision; implement them in a reliable and consistent manner; and utilize the results (T1f).

19. Revisit the new post move monitoring format as per the comments in T2a regarding comments, sentences, and paragraphs (T2a).

20. Show more active follow-up by the PMM to show that best efforts were put forward when supports were not being provided adequately or an individual's placement was becoming jeopardized (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o SGSSLC Guardianship Policy dated 5/10/02 o SGSSLC Rights of Individuals with Developmental Disabilities Policy date 10/12/01 o A sample of 12 completed Section U audit tools o SGSSLC Plan of Improvement updated 10/1/11 o SGSSLC Priority List for Adults without Guardians o Human Rights Committee Minutes for the past six months o Personal Support Plans: • Individual #248, Individual #194, Individual #39, Individual #294, Individual #132, and Individual #18. Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Roy Smith, Rights Protection Officer o Zula White, Rights Protection Officer Assistant Observations Conducted: o Observations at residences and day programs o Unit 1 Morning Meeting – 12/6/11 o Incident Management Review Team Meeting 12/6/11 and 12/7/11 o Human Rights Committee Meeting 12/7/11 o Annual PSP meetings for Individual #285
	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. It was updated on 11/22/11. In addition, during the onsite review, the Rights Protection Officer reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to both of the provision items in section U. It was unclear

	from a review of the POI how SGSSLC came to this self-rating. Nevertheless, the monitoring team was in agreement with these self-ratings.
	Summary of Monitor's Assessment: SGSSLC did not indicate that it was in compliance with any of the provisions of this section. The facility continued to take steps to address compliance. Some positive steps that the facility had taken in regards to consent and guardianship issues included: • Revisions had been made to the facility's rights assessment. • The Rights Protection Officer provided training to QDDPs on how to better determine ability to give informed consent. • Information on guardianship was presented to families. • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had a Self-Advocacy group comprised of individuals residing at the facility. • The Guardianship Committee continued to meet to discuss guardianship issues. • The Rights Protection Officer continued to work with local agencies to pursue advocates for individuals. • An audit process had been implemented using the statewide Section U audit tool. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. While the facility maintained a list of individuals needing an LAR, PSTs were not adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. While the facility was pursuing guardianship for a number of individuals at the facility, the efforts did not appear to be related to those individuals determined by the Facility to have the greatest prioritized need. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had a Human Rights Committee (HRC) in place to review restrictions requested by the PST. At the HRC meeting observed, committee members engaged in good discussion regarding the need for the proposed restrictions prior to giving approval. Individuals and/or a representative from the PST attended the meeting to present information before the committee in most cases.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility POI indicated that SGSSLC continued to move forward to meet the mandates of this provision. The facility was still waiting on the statewide policy, which was now in draft form, to be approved prior to developing a facility policy to address consent and guardianship issues. The facility POI indicated that SGSSLC was not yet in compliance with the requirements of item U1. The Rights Protection Officer had completed 12 Section U audits since 6/1/11. These audits included a review of the PST discussion regarding each individual's ability to give consent in relationship to the need for guardianship or advocacy. The facility self-assessment indicated that there had been progress made by PSTs in holding a meaningful discussion around consent issues. The facility had a list of 145 individuals at the facility that did not have an LAR. This list was prioritized by need. • Thirty-two individuals on the list were considered a Priority 1 (high need), • Thirty were considered Priority 2, and • Eighteen were considered Priority 3. • Sixty-five had been listed as non-priority for guardianship. • Seventy three individuals at the facility had guardians. • Guardianship was being sought for those individuals who had family that may be interested in guardianship first. A sample of PSPs was reviewed for evidence that the team had discussed the need for guardianship. Three of seven PSPs (43%) in the sample included an adequate discussion regarding the need for guardianship. According to the Rights Protection Officer, some teams were still struggling with assessing individual's ability to make informed decisions. He was providing technical assistance to team as needed. The following is a summary of finding from a sample of PSPs reviewed for individuals without guardians. • Individual #248 did not have a guardian. Her sister had been appointed as her guardian in 2004, but had not renewed guardianship after 2006. Her PST agreed that she was unable to give informed consent based on her assessments. The PSP included a good discussion of her need for guardianship. • The annual PSP for Individual #39 simply stated that he did not currently have a guardian and been referred for an advocate. There was no indication that the team discussed his ability to give informed consent. • The PSP for Individual #194 did not include a record of discussion regarding her ability to give informed consent or need for guardianship. • The PSP for Individual #294 indicated that the Guardianship Priority Tool was used to determine his need for a guardian. His ability to give informed consent was not discussed other than a statement regarding his "lack of knowledge and	Noncompliance

#	Provision	Assessment of Status	Compliance
		understanding of money." The team determined that he was a Priority 2 for guardianship. • The PSP for Individual #120 summarized the PST's discussion regarding his ability to make decisions. The team determined that he did not need a guardian. • The PST for Individual #132 discussed his ability to make informed decisions. Team members agreed that he did not have the ability to make informed decision in regards to medical, programmatic, or financial issues. The team determined that he could benefit from an advocate. It was not clear that guardianship was discussed. • The PSP for Individual #18 included a summary of the PSTs discussion of his ability to give informed consent and need for guardianship. The team determined that he was a Priority I need for a guardian. PSTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship should be based on this discussion. Though progress had been made towards substantial compliance, the facility was not yet in compliance with this provision.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The Rights Protection Officer also provided information to other community agencies on advocacy opportunities at the facility. The facility did have some rights protections in place including an assistant independent ombudsman housed at the facility and a rights officer employed by the facility. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at SGSSLC. As was found during the last monitoring review, the HRC engaged in thoughtful discussion of all rights presented to the committee. Individuals were still encouraged to come before the committee and were involved in discussion with committee members regarding any proposed rights restrictions. When individuals did not attend the meeting, a PST member was in attendance to present information and answer any questions from committee members. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.	Noncompliance

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).

2. Provide formal training to teach individuals to problem-solve, make decisions, and advocate for themselves (U1, U2).

3. Explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o Organizational chart, undated o SGSSLC policy lists, dated 10/31/11 o List of typical meetings that occurred at SGSSLC, (incomplete) o SGSSLC POI, 11/22/11 o SGSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/5/11 o SGSSLC policy: Active Record Guidelines, updated 5/19/11, by Marsha Jones, URC o Documents regarding medical department routing of consultations, and psychiatry note processing procedures o List of all staff responsible for management of unified records o Tables of contents active records and individual notebooks, updated 12/1/11 o Table of contents for the master record, 3/21/11 o Active record audit guidelines and training material, by Marsha Jones, URC o New Employee Orientation materials o Training rosters sign in sheets for new staff as well as for administrators and clinicians o Home secretary meeting notes, July 2011 through November 2011 o Blank audit tool to be used by home secretaries o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, dated 11/14/11 and 11/3/11 o Email regarding state office expectations for facility-specific policies, from central office SSLC director of operations, Donna Jesse, 3/15/11 o Blank statewide self-assessment tool, and facility's table of contents tool, November 2011 o Completed statewide self-assessment tools for section V, May 2011 through October 2011 o Graph presentations of the data from the self-assessment tools, showing data for a variety of different variables and separated across different discipline departments, September 2011 and October 2011 o Quality Assurance Report, section V, May 2011 through October 2011 o List of individuals chosen for recordkeeping audits, last six months, 30 individuals o 10 completed audits of active records, individual notebooks, and master records, September 2011 and October 2011 (five each month), included the state self-assessment form and the facility's table of contents/guidelines form. o Spreadsheet of actions required for one individual's review, along with various emails to responsible managers and clinicians regarding needed corrections (Individual #153) o Description of how the facility implements and assess the utilization of records o Results of V4 interviews following two PSTs, interviews of more than a dozen staff

	o Review of active records and/or individual notebooks of: • Individual #80, Individual #285, Individual #262, Individual #18, Individual #355, Individual #277, Individual #376 <u>Interviews and Meetings Held</u>: o Marsha Jones, Unified Records Coordinator o Becky McPherson, DADS Program Compliance Coordinator, and DADS State Office Recordkeeping Coordinator o Starla McLaren, home secretary, Margo Sellers, QDDP o Numerous staff and clinicians during observations in residences <u>Observations Conducted</u>: o Records storage areas in residences
	Facility Self-Assessment: SGSSLC submitted its self-assessment, called the POI. It was updated on 11/22/11. In addition, during the onsite review, the Unified Records Coordinator reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the URC wrote a sentence or two about what tasks were completed each month. This information was interesting and demonstrated the URC's high level of activity. The monitoring team, however, would prefer to have an understanding of the self-assessment process used by the recordkeeping department. For instance, the monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment. Further, the POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The URC self-rated the facility as being in noncompliance with all four provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI should be written to guide the department in achieving substantial compliance. A set of action steps was included in the POI and all were related to V3. A broader set of actions, such as those described in this monitoring report, should be set out as actions. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation of an action, but a timeline that will indicate the stable and regular implementation of each of these actions.

	Summary of Monitor's Assessment: SGSSLC demonstrated continued progress and had made a number of improvements in recordkeeping activities and records management. The URC, Marsha Jones, was organized, knowledgeable about all of the requirements of provision V, detailed in her work, and tenacious in her quality assurance audit reviews. Further, she had responded to the recommendations in the previous monitoring report. The URC engaged in a lot of training activities at the facility and provided training and supervision to the home secretaries. The active records reviewed by the monitoring team were neat and organized. Records contained documents as per the table of contents guidelines. There were, however, documents filed in the wrong individual's active record, legibility of entries continued to be an issue that needed to be addressed, and signatures and dates were missing from some documents. There were individual notebooks for all individuals, however, in many of the homes, the individual notebooks were kept in the locked records room. This continued to raise the question of how data could be collected and recorded reliably and accurately if the individual notebooks were stored in the records rooms. Master records were maintained in the same satisfactory manner as during the last onsite review. Tracking and management of state and facility-specific policies was done on a spreadsheet. It indicated continued progress. The tracking should also include information related to central office review. Further, a system of implementation and training of relevant staff needs to be created. The URC was now completing five reviews per month, as required. Overall, the reviews were done in a consistent and very detailed manner. Two forms were completed for each review: the statewide monitoring tool and the table of contents review tool. Across the 10 audit reviews, there was a consistency in the issues and problems identified by the URC. Upon completion of the review, the URC let relevant managers and clinicians know about what needed to be corrected. This was a very new part of the process for the URC. The data from the statewide monitoring tools were entered into the state database. The URC created a set of graphs showing the performance of the facility on the items of the statewide tool. These data were submitted to the QA department and were included in the monthly QA report. A next step is for the URC to create a set of graphs regarding the conduct and outcomes of the audit review process. To address the facility's use of the unified records to make treatment and care decisions, the URC had done brief interviews of a number of PST members. These data were interesting, but were not used by the facility. More activities will need to be undertaken. Direction will likely be provided by state office in the near future.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	SGSSLC demonstrated continued progress with this provision item and had made a number of improvements in recordkeeping activities and records management. The URC, Marsha Jones, was organized, knowledgeable about all of the requirements of provision V, and detailed in her work. State policy and facility-specific policies remained the same since the last onsite review and, therefore, no new comments are provided here. Two related procedures, however, were described by the URC that, although not managed by the recordkeeping department, showed that the URC was thinking about ways that the actions of other departments affected the overall operation of the unified records. These two policies/procedures were about the management of medical consultation documentation, and psychiatry processing of psychiatric clinic notes. The table of contents and maintenance guidelines were updated on 12/1/11. The URC had addressed the recommendation in the previous report to not remove items from the table of contents without state office approval. The URC engaged in a lot of training activities at the facility. First, she taught a section of new employee orientation. Second, she created a training for managers and clinicians that included descriptions of the unified record, checkout and use procedures, and expectations regarding managing and caring for the records, and how to make proper entries. She had done this training with more than 100 clinicians and managers. Third, the URC provided training to the home secretaries. She had begun a monthly meeting with the home secretaries. Topics listed on the agendas were relevant and reflected the minutes to which the home secretaries and the URC regularly attended. The notes showed that the URC had addressed the previous report's recommendation regarding home secretaries knowing what to do when they come across a document that is unclear as to where it should be filed. <u>Active records</u> The active records reviewed by the monitoring team were neat and organized. Records contained documents as per the table of contents guidelines, such as the PALS/FSA, PSP, SAPs, IEP, and IPNs. All of the active records had been moved into new binders. A few of the QDDPs and other staff told the monitoring team that they liked the new active record format better than what they had in the past. There were, however, documents filed in the wrong individual's active record (e.g., Individual #68's documents in Individual #80's active record, Individual #340's documents in Individual #376's record). Also, legibility of entries continued to be an issue that needed to be addressed. Signatures and dates were missing from some	Noncompliance

#	Provision	Assessment of Status	Compliance
		documents (as pointed out by the URC). QDDPs kept a log of notes. Some QDDPs made a new page for each note, some kept a running note. QDDPs at SGSSLC did not review the IPNs. Instead, they relied upon the RN casemanagers to keep them informed of any relevant information from the IPNs (i.e., related to clinical and health-related issues). SGSSLC should discuss this process, that is, whether it is acceptable for QDDPs to not read the IPNs. <u>Individual notebooks</u> SGSSLC had chosen to keep individual notebooks for all individuals. In many of the homes, the individual notebooks were kept in the locked records room. This continued to raise the question of how data could be collected and recorded reliably and accurately if the individual notebooks were stored in the records rooms. The URC reported that the facility was still working on adequately and thoroughly addressing this. The individual notebooks were organized in a typical and standard way. The individual notebooks in the homes where the notebooks were available to staff throughout the day were worn in a way that indicated that they were used regularly (e.g., Individual #18). <u>Master records</u> SGSSLC maintained the same satisfactory system of managing the master records. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	SGSSLC had two single spreadsheets that indicated the status of state policies and the status of facility-specific policies. These were maintained by the facility's QA director. One spreadsheet showed the status of each state and facility policy, the other showed more detail about the facility's activity regarding each facility-specific policy. Not all policies were yet in place, though continued progress was evident. For instance, the spreadsheet noted that facility-specific policies for five state office policies were developed since the last onsite review. The second, more detailed spreadsheet, also indicated why some state policies did not have a corresponding facility-specific policy (as recommended in the previous report). The spreadsheet, however, should be expanded to include all of the aspects of the DADS memo from 3/15/11 (as detailed in the previous monitoring report), that is, a column for date submitted to state office for approval, and date the policy was approved by state office (state office might have comments or edits that require the facility to make	Noncompliance

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		revisions; if so, this should also be noted on the spreadsheet). To show implementation and training of relevant staff on both the state policies and the facility-specific policies, the facility should develop a policy and system with the following components: • It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided. • For each policy, consideration should be given to defining who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility. • Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., PSP annual refresher training). • A system to track which staff had completed which training.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Continued progress was made towards substantial compliance with this provision item. Overall, the URC had worked hard and put into place some new procedures. She was now completing five reviews per month, as required. A list showing five completed for each of the previous six months was given to the monitoring team. The five from September 2011 and October 2011 were reviewed by the monitoring team. Overall, the reviews were done in a consistent manner. Two forms were completed for each review. One was the statewide monitoring tool for provision V. The other was the table of contents review tool for the active record, individual notebook, and master record. The URC used the table of contents review tool to indicate whether items were or were not in the active record, individual notebook, and master record. She also assessed the presence/absence of the components of these items (e.g., signature, legibility, date) and quality (when appropriate to do so). Then, she used this information to complete the statewide form. The URC was very detailed and diligent, if not tenacious, in her reviews. In addition to following the statewide tool and table of contents guidelines, she: • read all PSP quarterly reviews to see if any new SAPs were added, so that she could look for their presence in the SAP sections of the active record and the	Noncompliance

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		individual notebook, • looked to see if the IPNs contained notes regarding any relevant information she read in other places in the active record, such as in consultation notes or lab reports, and • looked for the medical department's new stamp on medical consultations and whether or not it was completed correctly. Across the 10 audit reviews (i.e., the statewide tool and the table of contents review), there was a consistency in the issues and problems identified by the URC. Below are some comments regarding these reviews: • The URC was very detailed in her review of documents and held a high and appropriate standard for the completion and quality of those aspects of the documents that she reviewed. • There were many items marked illegible, missing signatures, and/or missing dates. • Documentation in the medical consultation sections needed to be informed by the medical department's listing of consultations. This was mentioned in the previous report, but had not yet been adequately addressed. • A standard should be determined as to the deadline for annual and quarterly documentation to be filed in the record (e.g., annual PSPs, quarterly PSP reviews). Upon completion of the review, the URC let relevant managers and clinicians know about what needed to be corrected. This was a very new part of the process for the URC. She had created a spreadsheet for one review (Individual #153) that detailed approximately 70 needed corrections (typical of the number of needed corrections across the set of 10 reviewed by the monitoring team, though these were not counted and charted yet by the URC). She then sent out detailed emails to 18 different clinicians and managers regarding what each of them needed to correct. The clinician or manager was then to let the URC know when an item was corrected. She planned to then go to the record to confirm whether a sample of these were indeed corrected. This was an outstanding effort by the URC and should result in improvements in the content of the unified record, exactly the goal of conducing these types of review audits. Further, she had developed some methods for streamlining the process, such as an easy process for entering the information into the spreadsheet while she was doing the review, and a process for easily turning the contents of the spreadsheet into an email. At the time of the previous review, the URC was holding a PST meeting following each of the five monthly unified record reviews. She reported that this was overly time consuming for everyone and, therefore, she was moving towards addressing needed	

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		corrections by talking with the home secretary and sending out emails and the recommendations/corrections spreadsheet after each review. This seemed to be a reasonable way to proceed. The data from the statewide monitoring tools were entered into the state database. The URC recently created a set of graphs showing the performance of the facility on the items of the statewide tool, including a breakdown by item and by clinical department staff. These data were submitted to the QA department and were included in the monthly QA report, including a two (or so) page section of the QA report devoted to the URC's work and section V of the Settlement Agreement. This was all good to see. A next step is for the URC to create a set of graphs regarding the conduct and outcomes of the audit review process, such as the number of reviews conducted, the average number of corrections needed, and the number of corrections not completed after a two-month period. Lastly, the URC created a new tool for home secretaries to do active record and individual notebook reviews themselves for one individual each month beginning in December 2011. She planned to incorporate these data into her reporting.	
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.	Continued progress was demonstrated by the recordkeeping staff, however, more work will need to be done to determine the full set of activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. Recently, the monitoring teams, DADS and DOJ agreed that a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item that was submitted by the monitoring teams would be used by the facilities for the next onsite review. At this time, the URC had continued with the activity begun at the time of the previous review, that is, doing a brief interview of a small set of clinicians and managers regarding their use of the unified record. The results of these were not summarized or used by the facility in any way. Further, only talking with one PST member each month might not provide enough information for any generalizations to be made about the use of records. Rather than doing one interview, the URC did about a half dozen for the one individual's record, including clinicians and direct care staff. The information she reported was very interesting and appeared valid. One of the questions asked what improvements could be made in the unified record system and some very good responses were provided. The facility should consider what to do with all of this information, in particular, regarding the many suggestions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The URC told the monitoring team that the facility had identified a group that would be addressing this provision item. She noted that the facility had identified problems with the way records were available, accessed, moved, and returned to their assigned location. This seemed like a good next step. Some comments, based upon observations of the monitoring team, regarding the use of the records as required by this provision item are provided below. These illustrate some examples of the use of the unified record, but also show some of the challenges for the facility to address in meeting the requirements of this provision item. • The active record and individual notebook were present at the annual PSP meeting for Individual #376. During the meeting, his physician and psychiatrist used the active record to review prior diagnoses and medication regimens. • Individual notebooks were all locked in staff rooms, but that did not present a problem for data collection at SGSSLC because staff used the scan cards that could be carried by each of them. • During psychiatry clinic, the individual's record was available and the psychiatric practitioner referenced the document as clinically indicated. • The lead psychiatrist initiated a procedure to enhance documentation from multiple disciplines for the psychiatric quarterly follow-up. • As noted in the prior review, there continued to be problems ensuring that medical records were available to clinical professionals when needed. This was observed to occur even after the "record curfew" of 5:00 pm. • Since the prior review, there was improvement in the format of nurses' notes, which were mostly documented in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format. • As noted in the prior review, the content as well as signature/credentials appearing in some nurses' notes were not legible. Also, some nurses notes were unsigned and entries were obliterated without proper designation as an erroneous entry, and many nurses' notes continued to include uninformative, cryptic phrases that provided little, if any, specific, objective and/or subjective information to guide and direct planned interventions and/or caregivers' activities. Also, despite the many reasons why nurses documented progress notes and the vast differences in the content of the nurses' reports of subjective and objective data and their assessments, the singular plan that was almost always put forward was the plan to "Continue to monitor." • Current speech assessments were not consistently available in the individual records reviewed. There was also inconsistent documentation by Rehabilitation Therapy clinicians and, therefore, critical information was not readily available to all team members for making appropriate treatment and training decisions.	

Recommendations:

1. Reduce the number of documents that are in the wrong individual's active record and/or individual notebook (V1).
2. Address the need for entries and documents in the record to be legible, contain the needed signatures, and include the proper dates (V1).
3. Review and determine whether or not it is acceptable for the QDDPs to not read the IPNs (V1).
4. Determine a way to ensure that relevant information and data collection procedures are available to all individuals whose individual notebooks either do not remain with them all day and/or whose individual notebooks remain in the home records room (V1).
5. Complete the development of state and facility policies for each of the provisions of the Settlement Agreement; follow the state office guidelines written in the 3/15/11 memo (V2).
6. Create a process for the implementation and training of relevant staff on state and facility-specific policies. Please see detail in V2 (V2).
7. Determine what medical consultation documentation should be in each active record; one way is to have an up to date listing from the medical department that shows each individual, date, name of consultant, and type of consultation (V1, V3).
8. Determine the deadline/expectation for when annual and quarterly documents should be filed in the active record (V1, V3).
9. Make a data set and graphs for the monthly review audits done by the URC, such as the number done each month, the average number of corrections needed per individual, and the number of corrections not completed after a two month period (V3).
10. Implement all procedures to address V4 when disseminated from state office (V4).
11. Use the information obtained from the V4 interviews conducted by the URC (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ADA	American Dental Association
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
ASA	Aspirin
ASAP	As Soon As Possible

AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
AV	Alleged Victim
BBS	Bilateral Breath Sounds
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BON	Board of Nursing
BP	Blood Pressure
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia

CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMax	Concentration Maximum
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic obstructive pulmonary disease
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CR	Controlled Release
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale

DM	Diabetes Management
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
ECG	Electrocardiogram
EBWR	Estimated Body Weight Range
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENE	Essential Nonessential
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FNP	Family Nurse Practitioner
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent

FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GAD	Generalized Anxiety Disorder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
GYN	Gynecology
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
IDT	Interdisciplinary Team

IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
ISP	Individual Support Plan
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram

MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MED	Masters, Education
Meq	Milli-equivalent
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MHA	Masters, Healthcare Administration
MI	Myocardial Infarction
MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science
MSN	Master of Science, Nursing
MSPT	Master of Science, Physical Therapy
MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
N/V	No Vomiting
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NIELM	Negative for Intraepithelial Lesion or Malignancy

NL	Nutritional
NMC	Nutritional Management Committee
NMES	Neuromuscular Electrical Stimulation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
Pharm.D.	Doctorate, Pharmacy
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PNM	Physical and Nutritional Management

PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
PO	By Mouth (per os)
POI	Plan of Improvement
POX	Pulse Oximetry
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse

RNP	Registered Nurse Practitioner
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAP	Skill Acquisition Plan
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SDP	Systematic Desensitization Program
SETT	Student, Environments, Tasks, and Tools
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TED	Thrombo Embolic Deterrent
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia

TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
TX	Treatment
UA	Urinalysis
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VPA	Valproic Acid
VS	Vital Signs
WBC	White Blood Count
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old