United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
October 7-11, 2013

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Introduction

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 (ICF/MR) 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 and Healthcare Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

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

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. 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.

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

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

Organization of Report

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

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
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.

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.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

As always, the Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators of the Facility for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The Facility Director, Natalie Montalvo, was extremely supportive of the Monitoring Team's activities throughout the week of the compliance visit. The Facility made available to the Monitoring Team and number of staff members in order to facilitate the many activities required, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The Monitoring Team greatly appreciates all this assistance from staff throughout the Facility. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Dee Dee McWilliams, and the staff who assisted her to keep up with all our requests, especially Tammy Nicewarner, Susan Fletcher, Beverly Wade, Wendy Ashorn, and the Campus Coordination Department. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Too many other staff to mention assisted in numerous ways.

Second, the Monitoring Team found management, clinical and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at the Facility. Many positive interactions occurred between staff and Monitoring Team members during the weeklong onsite tour. All Monitoring Team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers and clinicians. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist the Facility in meeting the many requirements of the Settlement Agreement.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations conducted, and interviews held. Specific information regarding many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. It is the hope of the Monitoring Team that the information and recommendations contained in this report are credible and helpful to the facility.

Given the number of issues identified during the baseline review, it was expected that the change processes would take time. During this review, it was clear that the staff at the Facility had taken a number of steps to address identified issues and to comply with the Settlement Agreement. In a number of areas, progress had been made. In other areas, the foundation had been laid for change. In some areas, concerted efforts need to be made over the next six months to make the necessary improvements. The following report provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements are needed.

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 288 individuals.

Facility Self-Assessment. BSSLC continued to improve its process of assessing status of compliance, although this was somewhat variable, with thorough and data-based self-assessments found for some sections such as Sections C and K, others with very limited information such as Section G, and others ranging between these. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

In addition, BSSLC provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. This report also provides some comments about the action steps in order to assist the Facility to review its plans and ensure they will lead toward compliance and will provide an organized approach that can coordinate with the self-assessment.

Specific Findings

Following are summaries of specific findings for each Section of the Settlement Agreement:

Restraints
The Facility had made marked improvement with compliance with Section C of the Settlement Agreement. With one exception, remaining compliance issues relate to use of medical restraint.

- Positive Practices and Improvements Made
  - The Facility has continued to limit the use of crisis intervention restraint, with continued decrease in frequency of use of crisis intervention restraint. Chemical restraint was used only once during the six-month review period.
  - The Facility maintained its comprehensive and thorough system for the review of crisis intervention restraint episodes, including review of video surveillance tapes (with the staff who were involved in the restraint) when the restraint occurred in an area covered by the surveillance cameras. Psychology Department staff review 100% of restraints.

- With respect to crisis intervention restraint the documentation reviewed by the Monitoring Team showed substantial compliance in nearly all areas.

- Improvements Needed
  - Although, as noted above, the Facility conducted comprehensive review of restraint episodes, reviews conducted by the Unit IDT and the IMRT were not always sufficient to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint.
  - Documentation associated with medical restraint continued to need improvement.
  - Direct support professionals did not consistently retain knowledge of restraint policy.

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

The Facility continued to make progress in achieving substantial compliance with Section D. In its last report the Monitoring Team reported compliance with 16 Provisions. Based on this review the Facility was in compliance with 18. Since the last review the Facility experienced a significant increase in the number of allegations of abuse and neglect (55 to 122 when comparing six -month periods) and in confirmed findings (one to 14 when comparing six-month periods).

- Positive Practices and Improvements Made
  - The Facility now has a comprehensive policy on Abuse/Neglect and Incident Management.
  - The Facility continued to make improvements in the processes associated with the conduct of Facility investigations of serious incidents and the Facility review of non-serious discovered injuries (to rule out abuse/neglect).
  - Alleged perpetrators were consistently removed from direct contact with individuals immediately following the Facility being informed of an allegation.
  - Allegations of abuse/neglect were appropriately referred to law enforcement.
  - Investigations commenced within 24 hours of the incident being reported.
  - Recommendations coming from the Facility's investigation review process were tracked and recorded in a database until satisfactory evidence was provided to the IMC and reviewed by the Facility's UIR Committee and Incident Management Review Team.
  - The scope of the tracking and trending of incidents and injuries, and the analysis of these data, had significantly improved since the last review.
  - The staff training requirements associated with this section of the Settlement Agreement were up-to-date.
  - Investigation files were well organized.
  - Employee and volunteer background checks had occurred as required by policy.
- Improvements Needed

- Although the Facility continued to make improvements in the processes associated with the conduct of its review of DFPS investigations, the Monitoring Team in its review of investigations identified investigation issues which were not identified by the Facility review process.
- The Facility had not demonstrated consistent reporting of allegations and serious incidents within the timeframes required by policy and by the Settlement Agreement.
- The completion of investigations did not always occur within 10 days. Extension requests did not always describe "extraordinary circumstances" (as required by the Settlement Agreement), sometimes describing only overall workload issues.
- Investigation reports did not always provide a clear basis for the investigation conclusion, sometimes not considering all available evidence.

Quality Assurance

In its last review the Monitoring Team reported that quality assurance (QA) activity necessary to achieve compliance with Section E of the Settlement Agreement was still in a formative stage. This is still largely the case. While the Facility had improved practices from that observed at the last review there were still many elements of the QA process that appear fragmented and not operating as a QA system. The entire QA process needs to mature and become administratively reliable in all areas (e.g. data collection, inter-rater reliability, data compilation, data review, use of data for problem identification, developing and implementing CAPs, and evaluating the effectiveness of CAPs).

- Positive Practices and Improvements Made
  - There were facility policies that adequately supported the state policy for quality assurance.
  - The Facility had begun the process of developing key indicators and had drafted 14 quality indicators.
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- Improvements Needed.
  - The QA plan matrix did not include all self-monitoring tools and self-monitoring procedures.
  - There was not a complete and adequate data list/inventory at the Facility.
  - The Facility processes for initiating, implementing, and tracking CAPs had become slightly more organized than that observed the last review. There are still many improvements needed in CAP development, implementation, outcome monitoring, and related administrative systems.

Integrated Protections, Services, Treatments and Supports

The Facility had devoted considerable thought and resources to its integrated planning processes over the past six months and much progress appeared to be attributable to these efforts. Several key initiatives included the dedication of a DADS consultant to work with the QIDP department and the IDTs on ISP processes, the implementation of a Program Development Department for Skill Acquisition Plans (SAPs) and an energetic and creative Section S Strategy Team. At this point, these

efforts had not yet yielded substantial progress in the development and implementation of an integrated ISP for each individual that ensured individualized protections, services, supports, and treatments were provided, consistent with current, generally accepted professional standards of care. The Facility is encouraged to continue to build on its recent initiatives. It appeared the Facility was poised to make tremendous strides in the upcoming months if it remains focused.

- Positive Practices and Improvements Made
  - A revised ISP format and process had been introduced to the IDTs and considerable training and coaching was being provided.
  - The Monitoring Team found there were some examples of improved integration observed in planning meetings and record reviews, and some additional initiatives to provide and document competency-based training. As indicated in the summary above, the Monitoring Team was particularly impressed with early results from the newly implemented Program Development Department as it related to meaningful SAPs for individuals.
- Improvements Needed
  - The IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
  - ISPs still did not consistently specify 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 and meet identified needs.
  - Barriers to living in the most integrated setting did not consistently lead to goals, objectives, or service strategies.

<u>Integrated Clinical Services</u>

Overall, BSSLC continued to progress on meeting the requirements of Section H, although there were no provisions yet in which the Facility had achieved substantial compliance. A hallmark was the variability across disciplines in progress on a wide range of requirements, from timeliness and comprehensiveness of assessments to development and use of clinical indicators to timeliness of change in treatments and services based on clinical information.

- Positive Practices and Improvements Made
  - Completion of assessments in response to a change in status had continued to improve both in timeliness and content.
  - Diagnoses were generally consistent with the current versions of the DSM and ICD classification systems nomenclature, with the exception of seizure disorders.
  - Development and use of clinical indicators to assess individual health care had continued. Two additional medical conditions had been added to the data tracking sheets for chronic medical conditions. The Nursing Department provided indicators identified in Nursing protocols. The Pathway to Oral Intake included data to be taken for each

level of status/intervention. A next step will be for the Facility to implement procedures so these data can be available in a form that will provide trend data over time to clinicians to help them evaluate change or stability in health status.

- Improvements Needed
  - Adequacy and timeliness of assessments and evaluations continued to be variable. Required assessments are determined at the ISP Preparation meeting, but Facility data on timeliness did not account for which assessments were or were not required; therefore, it was not possible for the Facility or the Monitoring Team to determine accurately the timeliness of completion. The Facility should implement systemic actions to improve timeliness of assessments.
  - There were several disciplines or areas of functioning for which progress had been made in improving content and comprehensiveness of assessments, but this remained variable.
  - Although psychiatric diagnoses were consistent with DSM nomenclature, and the overall level of psychiatric evaluations is high, the quality of diagnostic formulations and underlying diagnostic justification is variable. There were several examples in which either diagnostic justification was not clearly stated, or there was no documentation of differential diagnosis and why alternative or additional diagnoses were not made.
  - The Facility had continued processes to ensure treatments and interventions were initiated timely and based on medical diagnoses. Several sections of this report document continuing improvements in timely implementation of treatments and interventions but also document examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. Improvement was variable across clinical disciplines, and improvement is still needed.
  - There was variability across disciplines and areas of service in the regular review of health status of individuals.

<u>Minimum Common Elements of Clinical Care</u>

Continuing improvement in collaboration and integrated planning were evident. Documentation of review and acceptance of recommendations was routinely found, and Provision G2 was found to have achieved substantial compliance.

- Positive Practices and Improvements Made
  - The Morning Debriefing provided an excellent venue for integrated discussion and identification of issues needing collaborative planning; participation was clearly integrated, and disciplines used this as an opportunity to provide education and information to other disciplines.
  - There were numerous interdisciplinary committees and workgroups.
  - Documentation of review and acceptance of recommendations was routinely found on consultation forms and in integrated progress notes (IPNs), and the minutes of Clinical Morning Report meetings documented examples of follow up with interdisciplinary teams (IDTs)

- The Facility had begun a monthly process of audit of consults and provided information on consults audited. Information was gathered by auditing a sample of consultations, using a standard audit form.

- Improvements Needed
  - Although there were examples of excellent integrated planning, there other examples in which this needed improvement. Integrated clinical planning and services continue to evolve; to achieve substantial compliance, the Facility needs to continue to help staff identify inconsistencies among assessments and related services, to improve the consideration of how risks in one area of functioning and health may affect other areas and the services needed, and ensure assessments are timely so the information from one discipline can be considered by others when planning supports and services.
  - Although there were examples of referral to interdisciplinary teams (primarily through the Morning Medical Debriefing) and discussion or documentation of follow-up action, referral through the consultation process itself was infrequent.

<u>At-Risk Individuals</u>

The BSSLC processes to demonstrate compliance with this section of the SA had improved significantly from that reported in the last review. The most notable improvements continued to be in the areas under supervision of the Habilitation Therapies Department. Additional improvements were noted in areas under the supervision of the Nursing Department.

The Facility is further along in fully implementing its At-Risk Individuals policy to guide the risk assessment process. Even though the risk assessment and mitigation process works more effectively with some disciplines than others and with some interdisciplinary teams (IDTs) better than others, the Monitoring Team noted overall improvement. Having written policy and procedural direction appears to have resulted in more consistent performance across the Facility.

- Positive Practices and Improvements Made
  - Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred.
  - Implementation, shortly before the last compliance visit, of an At-Risk Individuals policy to guide the risk assessment and review process. Implementation of this policy had apparently resulted in improved performance related to compliance with this section of the SA.
  - There was improvement in timely implementation of the assessment process following an individual being identified as at risk. This occurred in all examples reviewed for a sample of 12 individuals.
  - BSSLC continued to show an improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to physical and nutritional management and in completing psychiatric assessments to address at risk conditions.
- Improvements Needed

- Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP meeting it attended, further improvements are needed. This is especially true in the use of clinical data in making determinations of risk.
- The processes to implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan (IHCP) processes continued to evolve. Risk assessments consistently provided clinical data sufficient to determine health risk levels and to develop plans to address risk. However, it wa difficult to determine when IHCPs were implemented, and IHCPs were not consistently clinically sufficient to meet the needs for all identified risk ratings.

Psychiatric Care and Services

During the current review period Provisions J10 and J14 came newly into a status of substantial compliance with the requirements of the SA. Improvements were noted in the manner that information about treatment alternatives and risk vs. risk discussions took place. Considerable progress was made for many provisions even though the relevant provisions had not yet come into substantial compliance with all provision requirements.

- Positive Practices and Improvements Made
  - There was much progress on Provisions J3 and J13 around the modification of Behavioral Data Sheets (BDSs) that have long been used by psychology to track challenging behaviors. Steps have been taken to adapt BDSs so that psychiatrists will also receive data needed to determine medication treatment efficacy.
  - Progress has been made on Provision J8 via improvements in the psychiatry/psychology collaboration about tracking for medication efficacy.
  - Consistency of use of the ISPA for new medications has improved.
  - Lower rates of polypharmacy have been maintained and psychiatrist continued to complete polypharmacy justification statements during psychiatric treatment reviews.
- Improvements Needed
  - Not all individuals who required psychiatric assessments had received them.

Psychological services

Provisions K.2, K.3, and K.11 were in substantial compliance with the Settlement Agreement. Despite the lack of substantial compliance with other Provisions, the review process did reflect that the Facility had achieved progress in other areas.

- Positive Practices and Improvements Made
  - The Facility continued to strive toward all qualified staff becoming certified as behavior analysts. At the time of the site visit, 100% of eligible staff were either board certified or actively pursuing board certification.
  - The Facility had established a peer review process that was comprehensive and rigorous.
  - Efforts to collect and monitor behavior treatment data had improved, including the addition of monthly review of all

behavior data by BCBAs.
    - The quality of behavior interventions had improved substantially. In those cases where individuals presented with mental illness as well as behavior challenges, the Behavior Services Department demonstrated particularly adept skills in integrating the assessment of both issues.
- Improvements Needed
    - Although a number of individuals were provided with current intellectual and adaptive skill testing, such testing had slowed.
    - A substantial portion of individuals newly admitted to the Facility was not provided with timely assessments.
    - Counseling plans lacked a basis in evidence-based practices.

Medical Care

The Monitoring Team noted progress with medical provider's management of diabetes; participation at individual support plan (ISP) and Interdisciplinary Team (IDT) meetings; enhancement of examination rooms by providing modernized equipment, and examination tables; and maintaining a robust morning medical debriefing meeting to help ensure effective continuity of care. The Monitoring Team determined that the Facility continue to enhance development and implementation of its clinical practice.

- Positive Practices and Improvements Made
    - Participation by medical providers at IDT and ISP planning meetings had improved.
    - The Facility had enhanced its medical examination rooms, obtaining necessary clinical equipment and examination tables.
    - The morning debriefing meeting provides an effective process to help improve on continuity of care.
- Improvements Needed
    - The Facility must continue to enhance its clinical processes in the area of immunization, evaluation of DNR status, and following up on chronic clinical care issues.
    - The mortality review process must be significantly revised to ensure that medical providers conduct a comprehensive case review of all deaths, and that meaningful recommendations are provided for each death, derived by a root cause analysis. The Facility must conduct periodic analysis of all deaths, and when the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care.
    - The Facility must develop and implement a medical quality assurance process that tracks and trends positive outcomes and adverse outcomes for its medical practices. Furthermore, the process must include a mechanism for the development and follow-up of remediation efforts for all identified adverse outcomes and deficiencies.

Nursing Care

The Nursing Department showed significant progress in Section M Provisions, except Provision M.5, which is closely aligned with compliance with the Integrated Risk Rating and IHCP processes.

- Positive Practices and Improvements Made
    - If the requirements for staffing, Hospital Liaison Nurses, Infection Control, and Emergency Response System were standalone activities they would be considered in substantial compliance.
    - The Quality Assurance processes are well established, including inter-rater reliability processes.
    - The Nursing Department had fully implemented the revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. The RN Case Manager Supervisor had put forth concerted effort in training the RM Case Managers and reviewing the completed Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessments.
    - Acute Care Plans were exemplary.
    - The Facility had a robust competency based educational program that tracked all required training and ensured the training was completed.
    - There was evidence that the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficient to meet individuals' health care needs.
    - The Facility had a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances.
- Improvements Needed
    - The Facility continued to have a high incidence of pressure ulcers. The Facility needs to become more proactive and ensure that all relative disciplines work collaboratively to reduce/prevent pressure ulcers.
    - Although there was improvement in IHCPs, which met most criteria, action plans for nursing interventions need to contain more specificity as to what is monitored and documents.
    - The Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. These processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance.

<u>Pharmacy Services and Safe Medication Practices</u>
The Monitoring Team determined that the Facility continues substantial compliance for all provisions of Section N. Furthermore, the Monitoring Team noted during the visit that the pharmacy continued to make worthwhile improvements in processes that had already been found in compliance with the requirements for the provisions.

- Positive Practices and Improvements Made
    - All new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics.

- The Facility continues to produce exceptional Quarterly Drug Regimen Reviews (QDRRs).
- In response to temporarily falling behind schedule on completing QDRRs due to staffing issues, the Facility developed and implemented a process that included training of all pharmacists on how to complete QDRRs, so in the event of a staffing shortage in the future, all pharmacists will be enabled to help ensure that the Facility remains current with the QDRRs scheduled.
- The Facility continued to ensure that metabolic syndrome, polypharmacy, anticholinergic, and benzodiazepine usage is addressed when completing QDRRs and ensured that regularly scheduled systems review of benzodiazepine, anticholinergic, and polypharmacy usage is reviewed through relevant committee structure.
- The Facility continues to ensure that medical provider's review, and appropriately follow-up on pharmacy recommendations.
- Drug Utilization Evaluation provided clinically relevant information, and provided medical providers and pharmacists with information to enhance clinical practice.
- The Facility maintained a medication variance process that promptly addressed all reported medication variances, tracked and trended prescribing, documenting, dispensing, administering, storage of medication variances

- Improvements Needed
  - The Facility started using the electronic format for the MOSES and DISCUS assessments, and in three examples the medical provider had not completed the comment and assessment sections.
  - Although there was evidence to indicate that all relevant staff had been trained on reporting ADRs, the Monitoring Team was concerned over the lack of reporting of ADRs from staff other then the clinical pharmacist. The Facility must ensure more timely reporting of ADRs by staff.
  - The Facility should provide DUEs for all drugs that are commonly used medications in the community for which an FDA advisory has been issued, regardless of whether they are currently prescribed at the Facility.
  - The Facility should also ensure a process that documents the pharmacist's review of each medication variance, and when clinically appropriate, provides clinical recommendations.

<u>Physical and Nutritional Management</u>
Overall, there has been noted improvement with all provisions in Section O. BSSLC continued to show progress across areas that required direct clinical skill such as PNMT meetings or assessments as well as systems components such as implementation of PNM related strategies.

- Positive Practices and Improvements Made
  - BSSLC had a Physical and Nutritional Management Team that included all the relevant professionals and great strides had been made regarding the collection of data and the reviewing of this data to better identify system issues or respond to recurrent issues on a regular basis.

- PNMPs were readily available to staff. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs.
- Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem.
- Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake.

- Improvements Needed
  - The risk process continued to improve in its ability to identify those individuals who are at increased risk. PNMT assessments/reviews lacked evidence that all potential areas impacted by the change in PNM status were at a minimum reviewed/discussed as part of the meeting.
  - PNMPs were not being comprehensively reviewed by the individual's IDT during the annual ISP meeting and there was lack of consistent participation by Occupational Therapy, Physical Therapy and Speech Pathology at the ISP meetings. Additionally, while BSSLC addressed concerns with positioning details, it was noted to be a pervasive issue and one that BSSLC needed to address prior to obtaining substantial compliance.
  - Staff were observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were observed poorly positioned in their wheelchairs and in recliners.
  - A formal process did not exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals.
  - BSSLC had ample frequency of monitoring and there was evidence that monitoring occurred across many of the settings that were likely to provoke swallowing difficulties, but there was no evidence that staff or the individual was monitored across all three shifts. Additionally, there was not a clear process that outlined how data acquired through the monitoring would be analyzed.
  - There was limited evidence of monthly review by the QIDP to ensure the PNMP remained effective in mitigating risks associated with PNM.

<u>Physical and Occupational Therapy</u>

Overall, there continued to be improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at BSSLC. Assessments were much improved and did a respectable job in providing a comprehensive review of the individual. An area that saw marked improvement was the timeliness in which assessments were provided.

- Positive Practices and Improvements Made

- The Habilitation Assessment addressed the majority of components needed to fully assess an individual. Areas regarding comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills were slightly below the 90% threshold but showed marked improvement since the previous review.

- Improvements Needed
  - Therapy services were not consistently integrated into the ISP.
  - There was little evidence that individual's progress was reviewed and at least monthly.
  - Plans were not implemented as written. Individuals were observed without supportive devices and in positions that were likely to provoke concerns related to aspiration, skin breakdown and overall poor posture.
  - A formal process did not exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals.

<u>Dental Services</u>

The Facility had recently hired a new dental director, who shared with the Monitoring Team her ambition of assisting the Facility towards compliance. At the time of this review, the Facility had made little progress from the previous reporting period, and it is anticipated, that with the support of the new dental director, the Facility will develop many processes to improve dental services.

- Positive Practices and Improvements Made
  - The Facility had upgraded equipment for dental treatment.
- Improvements Needed
  - The Facility must develop a robust mechanism to address dental related database elements.
  - Annual evaluations must improve timeliness and comprehensiveness.
  - Management of dental emergencies needs to be improved.
  - Suction toothbrush practice should be enhanced.
  - The Facility must obtain dental x-rays per standard of care practice for special needs dentistry.
  - The Facility needs to improve processes to provide supports and services to reduce the need for pre-treatment sedation for dental services.
  - The Facility should improve monitoring of oral healthcare at the living areas and address oral healthcare issues in ISPs as appropriate.

<u>Communication</u>

BSSLC continued to show improvement with Section R. Assessments remained one of the stronger aspects of the Communication Section as information regarding comparative analysis demonstrated noted improvement. Suggestions

stemming from the Communication Assessment regarding the acquisition of communication related skills also showed signs of emerging.

- Positive Practices and Improvements Made
    - BSSLC was at full capacity with regards to Speech Pathologists and had recently opened another position for a Speech Therapy Assistant. All Therapists were board certified and licensed to practice in the state of Texas. All Therapists had evidence of participating in continuing education that was relevant to the field of practice.
    - Individuals identified as having decreased communication were being provided with the needed assessments.
- Improvements Needed
    - DCPs were not observed utilizing strategies to engage Individuals in using general area devices. Individuals receiving indirect communication supports did not have their plans reviewed at least quarterly by the QDDP. Staff responsible for implementing plans did not appear to be knowledgeable of the plans.
    - BSSLC had a monitoring process to address the presence and working condition of the AAC devices but were not consistently monitoring whether or not each device was effective and/or meaningful to the individual.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

It was encouraging that considerable effort was being invested in skill acquisition training. In addition, those responsible for guiding skill acquisition training at the Facility demonstrated a variety of skills and considerable enthusiasm. If BSSLC attends to the requirements of the Settlement Agreement and evidence-based practices, there is a reasonable expectation for continued progress. There were indications from the site visit and following review that the Facility had achieved progress in some areas of Section S. Despite these improvements, the Facility demonstrated minimal progress in several areas.

- Improvements Needed
    - The Facility had established a new Program Development Department and created the Section S Strategy Team as part of a broad effort to improve assessments and skill acquisition training.
    - New policies concerning skill acquisition training had been developed and implemented.
    - Elements of the SAPs, such as specific consequences, discriminative stimuli, the opportunity for the display of target behaviors, and documentation methodology reflected considerable improvement.
    - Skill acquisition programs in many cases were practical and could be implemented in the relevant environments.
- Improvements Needed
    - Formal task analyses were not completed as part of the development of skill acquisition programs.
    - The ISP, Personal Focus Assessment, and other assessments were not routinely used to identify personal needs or guide the development of skill acquisition programs.
    - Apart from vocational settings, minimal functional engagement for individuals living at the Facility was observed.
    - Community-based employment training had not expanded.

Most Integrated Setting

The Monitoring Team continued to find noncompliance for the Section. More work remained to ensure transitions were effectively planned and successfully implemented. A summary of noted progress included the continued impressive effort with the families of children, many of whom had previously expressed opposition to community living, to work toward movement to a more appropriate and integrated setting. The Monitoring Team again commends the Facility for its initiative in this area. Other positive developments noted included increased integrated discussion by Interdisciplinary Teams (IDTs) and additional augmentation of transition staffing to enhance education and awareness of community living options as well as increase the pace of transitions once a referral is made.

- Positive Practices and Improvements Made
  - The CLDP identified Facility staff responsible for actions, and the timeframes in which such actions are to be completed.
  - The CLDP was reviewed with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living.
  - The Community Placement Report was issued.
  - PMM Checklists continued to be completed in a timely and generally attentive manner.
- Improvements Needed
  - Although there was progress in the implementation of the ISP process, significant deficits remained that continued to hamper efforts to develop and implement adequate transition planning, including identification in the Community Living Discharge Plan (CLDP) of necessary services and supports. Thus, CLDPs did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living.
  - There remains a need to develop and implement individualized plans for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.
  - Continued improvements were still needed in the post-move monitoring (PMM) process to ensure a comprehensive review was taking place.
  - Alternate Discharges did not routinely include an adequate post-discharge plan of care that would assist the individual to adjust to the new living environment consistent with CMS-required discharge planning processes.

Consent

This Section was not yet in compliance. A summary of noted progress included the Facility's continued development of its commendable capacity to provide advocates for individuals as an alternative to guardianship, with some 34 individuals

currently having an advocate assigned. A new HRO had been recently hired and was developing strategies for further implementation of the requirements for this section.

- Positive Practices and Improvements Made
  - The Facility maintained a robust Advocacy program that provided assistance in decision-making to 34 individuals.
  - The Facility's Guardianship Committee continued to meet as called for in the DADS Policy.
- Improvements Needed
  - There was no statewide or local policy that addressed either a standardized process, methodology, or tool IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making, nor was there any evidence that IDTs were yet making any concerted effort to address capacity for decision-making or strategies to enhance these capacities.
  - The Facility did maintain a prioritized list of individuals lacking an LAR, which was updated on an ongoing basis based on referrals from the IDTs, but not all individuals on the list had yet been assigned a priority.

<u>Recordkeeping and General Plan Implementation</u>

The Facility continued to make progress in most areas of recordkeeping and policy development and implementation. The Facility maintained a unified record. A significant change had been made recently in the process for filing documents in the record. Rather than having each discipline file documents, these were no to be given to the record clerk for filing. This was intended as a systemic change to improve presence of current documents and accuracy of order of filing. Numerous new policies had been implemented. Use of the record had improved, although it remained somewhat variable.

- Positive Practices and Improvements Made
  - Records were generally in order, and documents were, for the most part, present and current, except for assessments.
  - Records were accessible; aside from the unified record, a computer shared drive permitted ready access to assessments and other documents.
  - Both DADS and BSSLC had developed numerous policies, and the process is ongoing.
  - The audit system did include random audits of five or more records and did have a process to monitor all deficiencies identified in each review to identify corrective actions that need to be taken.
  - The active record was routinely present at ISP and IDT meetings, and information from the record was used at many meetings.
- Improvements Needed
  - The Facility needs to develop a process to track accurately and improve timeliness of completing assessments.
  - Compliance with the requirements of Appendix D had decreased slightly.

- The Monitoring Team recommends the Facility establish a clear set of procedures to ensure training on policies meets the needs for implementation of those policies, and can be tracked to ensure all staff who need training receive it.
- The corrective action process for deficiencies identified in audits of individual records did not follow through to correction of all deficiencies nor address those corrections that required action to limit reoccurrence (such as retraining) when the records themselves could not be corrected (for example, for legibility issues). Thus, the audits themselves provide the information needed about the status of records, but the corrective action process needs improvement.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of the Facility. The Monitoring Team hopes the comments throughout this report are useful to the Facility as it continues to work toward meeting the requirements of 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:** 1. BSSLC Self-Assessment (9/23/13) 2. BSSLC Action Plan (9/19/13) 3. Section C Presentation Book (undated) 4. DADS Policy 001.1 Use of Restraint (4/10/12) 5. DADS SSLC Nursing Protocol: Pretreatment and Post-Sedation Monitoring (February 2011) 6. BSSLC Policy C.1 Restraint (12/31/12) 7. BSSLC Draft Policy C.2 Restraint for Behavioral Crisis 9/27/13 8. BSSLC Draft Policy C.3 Medical Dental Restraint 9/27/13 9. List of crisis intervention restraints (3/1/13-8/31/13) 10. List of medical restraint, including TIVA, since the last review (9/10/13) 11. List of Individuals with a Crisis Intervention Plan (undated) 12. Sample C.1: ten crisis intervention restraint records listed by the Facility in response to the Documents Request. This represented 10 of the 19 (53%) crisis intervention restraints reported by the Facility and included restraint of Individuals #317, #460, #52, #248 (2x), #173, #468, #568, #402, and #533 13. Sample C.2: random sample of 24 staff training and related records and the signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect 14. Sample C.3: ten medical restraint (five pre-treatment sedation and five TIVA) records listed by the Facility in response to the Documents Request. This represented ten of the 45 (22%) medical restraints reported by the Facility and included restraint of Individuals #76, #366, #250, #101, #102, #297, #237, #120, #475, and #436 15. Sample C.4: records associated with the one use of crisis intervention restraint which occurred off-campus (Individual #360) 16. Sample C.5: records associated with the one use of crisis intervention chemical restraint (Individual #367) 17. Sample C.6: records associated with the one instance of use of crisis intervention restraint four or more times in a rolling 30 day period (Individual #367) 18. Sample C.7: records associated with the one instance of use of protective mechanical restraint for self-injurious behavior (PMR-SIB) (Individual #425) 19. Staff training records for staff serving as restraint monitors for restraints in Sample C.1 20. DADS report "Percent of All Employees Completing Courses of Training Programs" 9/5/13 21. DADS report "Course Due/Delinquent for BSSLC" for various required courses 9/5/13 22. Restraint related staff training material 23. Minutes of Restraint Reduction Committee 4/11/13, 5/30/13, and 7/25/13 24. Log of restraint related injuries since the last review. 25. BSSLC Restraint Trend Report 9/30/13

	People Interviewed: 1. Terry Blackmon, PhD, BCBA, Chief Psychologist 2. Donna Bradley-Schrick, BCBA, Assistant Director of Behavioral Services 3. Kelcie Mauer, Psychology Associate 4. Victoria Morgan, M.D., Lead Psychiatrist 5. Mary Anne Brett, M.D., Medical Director 6. Ten Direct Care Professionals **Meeting Attended/Observations:** 1. QA/QI Council meeting 10/9/13 2. Restraint Reduction Committee meeting 10/10/13 3. Behavior Support Committee 10/8/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section C, in conducting its self-assessment, the Facility: • Used a monitoring/auditing tool in assessing compliance for the use of crisis intervention restraint. The tool used was developed by the Chief Psychologist and had been in use for approximately six months. This tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The tool was used by the Chief Psychologist for every crisis intervention restraint (a 100% sample) and included review of documentation, staff interviews, and video review when applicable. • The monitoring tool did not have standard instructions/guidelines but it was reported those are being developed. • Inter-rater reliability was occurring with another BCBA in the Behavioral Services Department conducting an independent review of a subset of the crisis intervention restraints using the same monitoring tool. The QA department had not been involved in the review of Section C compliance. • Did not use any monitoring/auditing tool for assessing compliance with Settlement Agreement requirements associated with use of medical restraint. • The Facility presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Presented findings based on specific, measurable indicators. o Measured the quality as well as presence of items. o Distinguished data collected by the Chief Psychologist versus the staff conducting the inter-rater reliability review. • The Facility rated itself as being in compliance with the following provisions of Section C: Provisions C.1, C.2, C.3, C.6, C.7.a, C.7.b, C.7.e, and C.7.g. This was consistent with the Monitoring Team's findings, except that the Monitoring Team also found substantial compliance with the requirements of Provisions C.7.c and C.7.d.

	The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. • Actions were reported as completed or in process. • The Facility data areas in need of improvement primarily related to medical restraint practices and nursing requirements associated with restraint use. • The action steps described in the Action Plan included assigned staff responsibilities, projected completion dates, and a set of steps likely to lead to compliance with the requirements of this Section.
	Summary of Monitor's Assessment: The Facility had made marked improvement with compliance with Section C of the Settlement Agreement. With one exception, remaining compliance issues relate to use of medical restraint. The Facility has continued to limit the use of crisis intervention restraint. In FY12 crisis intervention restraint was used an average of 20 times a month. In FY13 this decreased to six times a month. In the first month of FY14 crisis intervention restraint was used only twice. The Facility rarely used chemical restraint, only once since the last review. The Facility maintained its comprehensive and thorough system for the review of crisis intervention restraint episodes, including review of video surveillance tapes (with the staff who were involved in the restraint) when the restraint occurred in an area covered by the surveillance cameras. Psychology Department staff review 100% of restraints. Reviews conducted by the Unit IDT and the IMRT were not always sufficient to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. With respect to crisis intervention restraint the documentation reviewed by the Monitoring Team showed substantial compliance in nearly all areas. This was not the case with documentation associated with medical restraint. Crisis intervention restraint was only used if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted, and restraints were terminated as soon as the individual was no longer a danger to him/herself or others. The Facility needs to engage in additional strategies to reinforce key provisions of restraint policy with Direct Support Professionals such as periodic competency checks (the Facility reported competency checks were previously done but had been discontinued). Lack of staff knowledge retained from training, at least as demonstrated by a small sample of employees, will have a negative effect on future compliance.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>The Facility continued to minimize use of crisis intervention restraint. Data presented at the October 9, 2013 QAQI Council meeting showed that in FY12 the Facility averaged 20 restraints per month. This decreased to six restraints per month in FY13. For the first month of FY14 (September, 2013) restraint was only used twice. This is especially commendable because the Facility has had admissions of Individuals with very challenging behavior.

For comparison purposes, data was provided to the Monitoring Team by the Facility for the past two six month periods showing:

<table>
<tr><th>Type of Restraint</th><th>9/1/12 to 2/28/13</th><th>3/1/13 to 8/31/13</th></tr>
<tr><td>Crisis Intervention (physical holds)</td><td>37</td><td>30</td></tr>
<tr><td>Crisis Intervention (chemical restraint)</td><td>1</td><td>2</td></tr>
<tr><td>Crisis Intervention (mechanical restraint)</td><td>0</td><td>2</td></tr>
<tr><td>TOTAL Crisis Intervention Restraints</td><td>38</td><td>33</td></tr>
<tr><td>TOTAL Individuals represented in above total</td><td>25</td><td>24</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>8</td><td>3</td></tr>
<tr><td>Medical restraints</td><td>42</td><td>45</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>42</td><td>36</td></tr>
</table>

Due to the timeframe of this table, it shows two chemical restraints for the most recent period. However, one of those occurred in March 2013, so there was only one in the six month period prior to the compliance visit, from April 2013 through September 2013.

Note: The Monitoring Team, in reviewing the QAQI Council minutes for October noted slightly different restraint numbers than that reported by the Facility for the above table. The Facility needs to ensure the accuracy and consistency of data provided to the</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Monitoring Team. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on review of other documentation (trend reports, Restraint Reduction Committee minutes, investigation reports, and lists of restraints) prone restraint was not identified. A sample, referred to as Sample C.1, was selected. (a list of restraints in Sample C.1 is provided in the Documents Reviewed Section above.) Based on a review of the restraint records for individuals in Sample C.1 involving 10 Individuals, none showed use of prone restraint. Based on questions with 10 direct support professionals, seven (70%) were aware of the prohibition on prone restraint. This represented regression from the 100% reported in the last review. These 10 staff was from residential areas where restraint had been used. An example of a negative response to the query "under what circumstances is it OK to use prone restraint?" was "when an Individual is doing harm to self and others". Note: Immediately after the Facility learned of these results it retrained all staff. <u>Other Restraint Requirements</u> Based on document review, the Facility and State policies do state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 10 of the 10 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • For the 10 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 10 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. • In 10 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or	

#	Provision	Assessment of Status	Compliance
		considered in a clinically justifiable manner. • Facility policies do identify a list of approved restraints. • Based on the review of 10 restraints, involving nine individuals, 10 (100%) were approved restraints. In 10 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. The Facility had one instance of restraint use considered to be PMR-SIB. This was an application of soft mittens for 90 minutes. The Monitoring Team reviewed this restraint application (Sample C.7). In this one instance, required policy and procedure for the use of PMR-SIB was followed. The Monitoring Team reviewed four Individuals who used abdominal binders related to G/J tube placement (Individuals #29, #428, #35, and #41). In each case the Individual's most recent ISP Addendum explained the purpose of the abdominal binder being a medical support and not a restraint. This was validated in the physician order for the abdominal binder. Based on this review this Provision was in substantial compliance. The testing of staff knowledge has become an additional requirement for compliance and the Facility will be expected to achieve a compliance score of at least 90% in the next review to maintain compliance. Lack of staff knowledge of basic and essential requirements of restraint policy runs the risk of unsafe behavior management practices, including application of restraint that does not comply with Facility policy.	
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 Crisis Intervention Plans that defined the use of restraint. For the three individuals who had Crisis Intervention Plans, the Facility presented sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. For seven individuals who did not have Crisis Intervention Plans, seven (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review this Provision was in substantial compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Some Facility policies related to restraint are discussed above with regard to Provision C.1 of the Settlement Agreement. In addition, the Facility had recently developed a draft of a reformatted restraint policy by creating one policy for crisis intervention restraint and one policy for medical restraint; this was awaiting final approval and implementation. The Facility had been (and still is) struggling with various aspects of use of medical restraint. Facility leadership felt that separate policies would provide clearer direction to various facility staff responsible for restraint administration and review. Review of the Facility's training curriculum revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample C.2 was selected from a current list of staff. A description of Sample C.2 is provided in the Documents Reviewed section above. 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: • 24 of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • 24 of the 24 (100%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. • 24 of the 24 (100%) had completed PMAB training within the past 12 months. • 24 of the 24 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. In order to evaluate staff knowledge in the area of restraint, 10 Direct Care Professionals were asked a series of questions. The 10 staff were selected by the Monitoring Team and included both am and pm staff. Seven of the 10 had been involved in restraint application since the last review. Each response was evaluated by one member of the Monitoring Team, the Facility's Assistant Director of Behavioral Services, and the Facility's Quality Assurance Director. Consequently, for each question, responses were subjected to 30 evaluations (ten staff times three raters). Based on responses to questions, the 10 direct support professionals provided satisfactory responses to the following questions as follows:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• "Policies governing the use of restraint require that restraint should only be used if the Individual poses a _____and after_____." Seven of 30 responses were evaluated as satisfactory (23%). This represented regression from the 53% reported in the last review; • "Describe an example of a verbal redirection technique." Twenty-nine of 30 responses were evaluated as satisfactory (97%). This was an improvement from the 57% reported in the last review; • "Describe two restraint techniques approved for use at the Facility." Twenty-one of 30 responses were evaluated as satisfactory (70%) This represented regression from the 80% reported in the last review; • "What level of supervision is usually required when an Individual is in restraint?" Sixteen of 30 responses were evaluated as satisfactory (53%). This represented regression from the 83% reported in the last review. These data suggests staff are not retaining information learned in formal training classes. As reported in previous reports by the Monitoring Team the Facility needs to engage in additional and effective strategies to reinforce key provisions of restraint policy. Staff should be able to articulate that restraint is only to be used if the individual poses an immediate and serious risk of harm to him/herself or others and after a graduated range of less restrictive measures has been exhausted, state at least one example of a verbal redirection technique, two examples of approved restraint techniques, that 1:1 supervision is ordinarily required when a person is in restraint, and that there is no circumstance where prone restraint is allowable. Note: Immediately after the Facility learned of these results it retrained all staff. In 10 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Based on this review this Provision was in substantial compliance. Competency-based training had been completed for all staff reviewed, and all restraint records reviewed showed restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, staff retention of information learned in formal training was problematic. The testing of staff knowledge has become an additional requirement for compliance and the Facility will be expected to achieve a compliance score of at least 90% in the next review to maintain compliance. Lack of staff knowledge of basic and essential requirements of restraint policy runs the risk of unsafe behavior management practices, including inappropriate application of restraint.	

#	Provision	Assessment of Status	Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 10 restraint records (Sample C.1), in 10 (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of seven Positive Behavior Support Plans, in seven (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. The Facility did not maintain a "Do Not Restrain" list but did use a "Considerations For Implementing Restraint" form to document physician and IDT review of physical, medical, and any other conditions or factors that would indicate a need to restrict or modify restraint use. This form, properly completed and signed, was in place for all 10 (100%) restraints reviewed pursuant to Sample C.1. In 10 of 10 restraint records reviewed (100%), there was no evidence that the restraint used was in contradiction to the individual's ISP, PBSP, or crisis intervention plan. In reviewing 10 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Six (60%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • Two (20%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and • None (0%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled Examples where this was not the case included all restraints in Sample C.3 Based on this review this Provision was not in substantial compliance because of issues related to use of medical restraint.	Noncompliance
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	Review of Facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. This training was competency-based. Based on review of training records, seven staff at the Facility who performed the duties of a restraint monitor for Sample C.1 all (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	restraint. Based on a review of 10 restraint records (Sample C.1), a face-to-face assessment was conducted: • In 10 (100%) by an adequately trained staff member. • In 10 (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. • In 10 (100%), the documentation showed that an assessment was completed of the application of the restraint • In 10 (100%), the documentation showed that an assessment was completed of the consequences of the restraint. There were no instances where a physician had ordered alternative monitoring schedule. Based on a review of 10 restraint records for restraints that occurred at the Facility (Sample C.1), there was documentation that a licensed health care professional: • Conducted monitoring at least every 15 minutes from the initiation of the restraint in nine (90%) of the instance of restraint, as required by DADS Policy Number 001.1, Use of Restraint, 4/12. Records that did not contain documentation of this included: o Individual #468: On 5/6/13 at 10:40 a.m., Individual #468 was physically restrained. The Crisis Intervention Restraint Checklist did not contain documentation that the licensed health care professional monitored Individual #468. • Monitored and documented vital signs in nine (90%). Records that did not contain documentation of this included: o Individual #468: On 5/6/13 at 10:40 a.m., Individual #468 was physically restrained. The Crisis Intervention Restraint Checklist did not contain documentation that the licensed health care professional monitored Individual #468's vital signs every 15 minutes, as required by policy. o Individual #568: On 7/22/13 at 8:35 a.m. and at 8:50 a.m., Individual #568 was physically restrained. The nurse documented on the Crisis Intervention Restraint Checklists that Individual #568 refused to allow vital signs taken. However, the accompanying Integrated Progress Notes documented that multiple attempts were made every 15 minutes to take vital signs, but all attempts were refused. As a result, monitoring of this restraint was acceptable. • Monitored and documented mental status in nine (90%). Records that did not contain documentation of this included: o Individual #468: On 5/6/13 at 10:40 a.m., Individual #468 was	

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		physically restrained. The Crisis Intervention Restraint Checklist did not contain documentation that the licensed health care professional monitored Individual #468's mental status every 15 minutes, as required by policy. o Individual #568: On 7/22/13 at 8:35 a.m. and at 8:50 a.m., Individual #568 was physically restrained. The nurse documented on the Crisis Intervention Restraint Checklists every 15 minutes that Individual #568 was alert. The accompanying Integrated Progress Notes documented detailed descriptions of Individual #568's mental status/behaviors during the restraint episodes. As a result, monitoring of this restraint was acceptable. • Monitored and documented whether restraint-related injuries occurred for physical restraint episodes. In 10 of 10 (100%) instance of restraints the Crisis Intervention Restraint Checklists for Injury were documented. Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. For this restraint (Sample C.4) a licensed health care professional: • Conducted monitoring within 30 minutes of the individual's return to the Facility in one out of one (100%). • Monitored and documented vital signs in one (100%). • Monitored and documented mental status in one (100%). Sample C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 22% of the individuals for whom medical restraint was used. (Sample C.3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In five of 10 (50%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • In none of 10 (0%), the physician specified the type of monitoring required. • In four of 10 of the medical restraints (40%), appropriate monitoring was completed either as required by the facility policy, or as the physician prescribed. Based on this review this Provision was not in compliance because of issues associated with medical restraint.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury;	A sample (Sample C.1) of 10 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements:	Noncompliance

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	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.	• In 10 (100%), continuous one-to-one supervision was provided; • In 10 (100%), the date and time restraint was begun; • In 10 (100%), the location of the restraint; • In nine (90%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. The exception was restraint of Individual #568; • In 10 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per Provision C.8. • In 10 (100%), the specific reasons for the use of the restraint • In 10 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In 10 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including: o One restraint was reported to last longer than 15 minutes (25 minutes). The Restraint Checklist documented adequate observation throughout the 25 minute restraint episode; • In 10 (100%), the level of supervision provided during the restraint episode; • In 10 (100%), the date and time the individual was released from restraint; and • In 10 (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. In a sample of ten records (Sample C.1), restraint debriefing forms that contained data consistent with that reported on the Restraint Checklist had been completed for nine (90%). The exception was restraint of Individual #248 (9/16). The Restraint Checklist reports an injury, the debriefing document reports that no injury report was initiated, and the restraint file prepared for the Monitoring Team included an injury report associated with the restraint episode. A sample of 10 Individuals subject to medical restraint was reviewed (Sample C.3), and in none (0%), was there evidence that the monitoring had been completed as required by the primary care provider's order. Primary care provider orders specifying the type and schedule for monitoring were either missing or did not include both the type and schedule of monitoring required. Sample C.5 included the one instance of use of a chemical restraint for crisis intervention. In this one instance, there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not	

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		conditions for administration of a chemical restraint had been met. Based on this review this Provision was not in substantial compliance because of issues associated with medical restraint monitoring. In its last report the Monitoring Team in determining substantial compliance noted that medical restraint monitoring, as specified by the physician, had not been assessed in prior reports but was an important component of ensuring monitoring is done appropriately in order to maintain safety, and noted that documentation of medical restraint monitoring, as specified by the physician, would need to be presented at this review for this Provision to remain in compliance. There was not sufficient evidence presented to the Monitoring Team to conclude this occurred.	
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 Facility documentation, during the six-month period prior to the onsite review, a total of three individuals were placed in restraint more than three times in any rolling 30-day period. Two individuals were met the criteria for review (placed in restraint more than three times in any rolling 30-day period), while the third individual met the criteria for review twice, for a total of four required reviews. A sample (Sample C.6) of three of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. Regarding review of adaptive skills and biological, medical, psychosocial factors: • In four of the four instances that met criteria for review (100%), documentation reflected an ISPA was conducted. Documentation also reflected that each review occurred within one week of criteria being met, with a minimum interval of zero days (review occurred on the day of restraint) and a maximum interval of six days. • Of the three individuals reviewed, three (100%) of individuals' teams (as reflected in ISPAs) discussed each individual's adaptive skills and biological, medical, and psychosocial factors and raised questions about all of these variables, thereby acknowledging the possibility of these variables impacting the individual's behavior. • Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in three of the cases (100%). Of these, there was evidence of an action plan or discussion/recommendations, identified in the ISPA, for modifying them to prevent the future probability of restraint in three of the cases	Substantial Compliance

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		(100%). An example of appropriate review involved Individual #38. For this individual, restraints were required when the individual resisted essential medical procedures and became violent. The IDT identified behavioral, adaptive skill, and medical factors that could have contributed to the need for restraint. Behavioral challenges and adaptive skill deficits were targeted in programmatic interventions in place at the time of restraint. Of greater concern from the perspective of the IDT was the apparent loss of global cognitive abilities. The IDT asked for and obtained psychiatric assessments and a computed tomography (CT) scan of the brain. Although results were not conclusive, the IDT agreed that neurological issues likely contributed to the ultimate need for restraint in the reviewed circumstances. Monitoring of cognitive status was implemented and procedures for administering medical care were modified to reduce the probability of behavior requiring restraint.	
	(b) review possibly contributing environmental conditions;	Regarding review of possibly contributing environmental conditions: • In four of the four instances that met criteria for review (100%), documentation reflected an ISPA was conducted. Documentation also reflected that each review occurred within one week of criteria being met, with a minimum interval of zero days (review occurred on the day of restraint) and a maximum interval of six days. • Of the three individuals reviewed, three (100%) of individual's teams (as reflected in ISPAs) discussed environmental factors for each individual, thereby acknowledging the possibility of these variables influencing the individual's behavior. • Of these individuals, environmental factors were hypothesized to affect the behaviors that provoke restraints in one of the cases (33%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in one of the cases (100%). An example of appropriate review involved Individual #367. Review by the IDT revealed that until shortly prior to the restraint the individual had been provided snacks upon request, which had led to excessive consumption of snacks (24 bags of chips and 12 soft drinks in a single day). Access to snacks had been substantially reduced, and the IDT agreed that the behavior prompting restraint was likely part of an extinction burst. It was agreed that the behavior would be monitored, and that efforts would be implemented to teach requests for items other than snacks and soft drinks.	Substantial Compliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Regarding review of, or performing, structural assessments: • In four of the four instances that met criteria for review (100%), documentation reflected an ISPA was conducted. Documentation also reflected that each review occurred within one week of criteria being met, with a minimum interval of zero days	Substantial Compliance

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		(review occurred on the day of restraint) and a maximum interval of six days. • Of the three individuals reviewed, three (100%) of individual's teams (as reflected in ISPAs) discussed environmental antecedents for each individual, thereby acknowledging the possibility of these variables influencing the individual's behavior. • Of these individuals, environmental antecedents were hypothesized to affect the behaviors that provoke restraints in one of the cases (33%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in one of the cases (100%). The specifics were discussed above in Provision C.7.b.	
	(d) review or perform functional assessments of the behavior provoking restraints;	Regarding review of, or performing, functional assessments: • In four of the four instances that met criteria for review (100%), documentation reflected an ISPA was conducted. Documentation also reflected that each review occurred within one week of criteria being met, with a minimum interval of zero days (review occurred on the day of restraint) and a maximum interval of six days. • Of the three individuals reviewed, three (100%) of individual's teams (as reflected in ISPAs) discussed the variable or variables that potentially were maintaining the behavior provoking restraints, • Of these individuals, functional assessments pertaining to behaviors that provoked restraints were current and adequate in two of the cases (67%). There was evidence of an action plan to improve the assessment of variables maintaining the behavior that provokes restraint in the remaining case. For Individual #248, the individual for whom the action plan was developed, no functional assessment had been completed at the time of the restraint due to the recent admission of the individual. It was documented in the ISPA that a functional assessment would be completed within three weeks.	Substantial 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,	Regarding development and implementation of a PBSP:
		• Three of three individuals (100%) were provided with a written behavioral intervention plan. For two individuals this consisted of a PBSP: the third was provided a Behavioral Admission Plan. Only one of three individuals (33%) was provided with a crisis plan. Of the two remaining individuals, one did not have a crisis plan due to recent admission, while the second did not have a crisis plan as his behavior had not previously required restraints.
		  • One of one (100%) crisis intervention plans delineated the type of restraint authorized.
		  • One of one (100%) of crisis intervention plans specified the maximum duration of restraint authorized.
			Substantial Compliance

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	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;	• One of one (100%) crisis intervention plans specified the designated approved restraint situation. • One of one (100%) crisis intervention plans specified the criteria for terminating the use of the restraint. • Three of three behavior interventions (100%) had operationally defined target behaviors • Two of three behavior interventions (67%) contained functional replacement behaviors. • None of three behavior interventions (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. Based upon the structural and functional assessments, the IDT did not identify a need for other programs. • Two of three behavior interventions (67%) contained interventions to weaken or reduce the behaviors that provoked restraint that are clear, precise and based on a functional assessment. • One of one (100%) crisis intervention plans delineated the type of restraint authorized. • One of one (100%) of crisis intervention plans specified the maximum duration of restraint authorized. • One of one (100%) crisis intervention plans specified the designated approved restraint situation. • One of one (100%) crisis intervention plans specified the criteria for terminating the use of the restraint.	
	(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	The documentation for three of three individuals (100%) having more than three restraints in a rolling 30 days included treatment integrity data. Despite the availability of treatment integrity data, the ISPAs for two of the individuals reflected that the IDT did not consider treatment integrity adequate. • For Individual #367, the IDT review reflected that although treatment integrity observations had been conducted, replacement behaviors were never observed. As a result, the IDT determined, "Rather than increase any treatment integrity observations the team feels that it would be more important to retrain staff on teaching replacement behaviors and then subsequent treatment integrity can determine if this is occurring per the instructions in the plan." This indicated that there were concerns about the implementation of the intervention plan, but it also provides an example of the IDT addressing the concerns. • For Individual #248, the IDT indicated on 8/23/2013 that the individual had "not been here long enough for us to have completed numerous Treatment Integrities to know if there is any pattern to the intervention not being implemented at a level of fidelity." On 8/31/2013, the IDT indicated in the ISPA that treatment integrity was adequate. As only one additional staff had been	Noncompliance

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		observed for treatment integrity since 8/23/2013, it was doubtful that the ability to identify "any pattern to the intervention not being implemented at a level of fidelity" had substantially improved. Based upon documentation and IDT statements, only one of three written intervention plans (33%) was considered to reflect adequate treatment integrity. Of the two that did not reflect adequate treatment integrity, the IDT was addressing one (50%).	
	(g) as necessary, assess and revise the PBSP.	Regarding assessing and revising the PBSP: • Three of three individuals (100%) were provided with a written behavioral intervention plan. For two individuals this consisted of a PBSP: the third was provided a Behavioral Admission Plan. For three of three individuals (100%) there was a review of the behavior intervention in the ISPA. • Of these individuals, the ISPA indicated that a revision was necessary in none of the cases (0%). As reflected in Provisions C.7.a and C.7.b, the IDT provided careful consideration of the intervention plans for all three individuals and indicated no need for revisions.	Substantial 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.	The BSSLC process for reviewing each episode of restraint starts with a Face-to-Face Assessment/Debriefing (FFAD) with the first three sections completed by the restraint monitor immediately after the restraint episode and a fourth section completed by a psychologist after interviewing staff involved in the restraint as well as the Individual restrained. The restraint episode is reviewed in the unit morning meeting the next business day after the restraint episode with whatever information has been prepared by the time of the meeting. This often consisted of verbal reports from staff. It is usually reviewed that same day by the Incident Management Review Team (IMRT), again usually based on verbal reports from staff, either the Unit Director, behavioral services staff, or both. The restraint use is also reviewed by the Individual's IDT within one working day of occurrence if the Individual does not have a Crisis Intervention Plan. If a restraint was recorded by the Facilities video surveillance system the video is reviewed and observations of the restraint episode are recorded on a Video Restraint Review Form. This provided additional opportunities for staff training and to ensure data recorded on the Restraint Checklist (RC) and FFAD was accurate, and if not, corrected. Restraint procedures were also reviewed at the monthly Restraint Reduction committee, typically focusing on restraint procedures associated with policy implementation issues, for example, the use of PMR-SIB, and the use of medical restraint, including TIVA. The circumstances associated with frequently restrained Individuals are sometimes presented as "case studies" at these meetings. Additionally, the Quality	Noncompliance

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		Assurance/Quality Improvement Council included a review of SA Section C compliance on its agenda in each monthly meeting. This would typically not include any discussion of an individual episode of restraint but did ensure a broader base of general review of restraint data and restraint practices at the BSSLC. The files produced pursuant to Sample C.1 included this Facility-specific restraint review process in all 10 (100%) restraint episodes. Documentation related to 10 incidents of non-medical restraint was reviewed (Sample C.1), including the Restraint Checklist, the Face-to-Face Assessment and Debriefing Form, the Unit Team meeting and IMRT meeting minutes, Restraint Reduction Committee minutes, and ISP addenda. This documentation showed that: • In 10 (100%), the review by the Unit IDT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist. • In 10 (100%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist. A BCBA was at each IMRT meeting. • In 10 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • In zero (0%), the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. The primary deficiency in this requirement was the absence of sufficient information to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. • In 10 (100%), referrals were made to the team, as appropriate; and • Of the 10 referred to the team, appropriate changes were made to the individuals' ISPs and/or PBSP in each case (100%). Sample C.7 included the one instance of use of chemical restraint. For this one chemical restraint, the clinical review conducted by the pharmacist and psychiatrist was sufficiently detailed to determine whether the chemical restraint was used in a clinically	

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		justified manner; that medication related risks were considered prior to the use of the chemical restraint; of the apparent effectiveness of the chemical restraint in reducing the dangerous behavior in the hours after administration; and that relevant recommendations were made by the pharmacist and the psychologist. This information was correctly documented on the Post- Chemical Restraint Clinical Review form and was signed by the pharmacist and the psychiatrist. Based on this review this Provision was not in substantial compliance because of the absence of sufficient information to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. The Director of Psychology reported this to be a documentation issue and indicated future restraint review would be sure to document the substance of the restraint review, including the above Settlement Agreement requirement, in the minutes of both Unit IDT meetings and IMRT meeting.	

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (9/23/13) 2. BSSLC Action Plan (9/19/13) 3. Section D Presentation Book (undated) 4. DADS Policy 021.2 – Protection From Harm – Abuse, Neglect, and Exploitation (12/4/12) 5. DADS Policy 02.4 Incident Management (11/20/12) 6. DADS State Supported Living Center Procedure: Injury Audits (undated) 7. Draft BSSLC Policy D.1 Protection from Harm-Abuse, Neglect, and Exploitation (5/1/13) 8. Draft BSSLC Policy DD.1 Incident Management (5/1/13) 9. BSSLC Policy DD.2 Injury Reporting Semi-Annual Under Reporting Audits (8/24/13) 10. BSSLC Policy D.5: Prohibition Against Retaliatory Action (5/15/13) 11. BSSLC Policy D.7: Placing & Monitoring Alleged Perpetrators On Non Direct Care (NDC) Status (8/3/13) 12. Form 1020 for sample of 24 employees 13. Your Rights and Zero Tolerance posters 14. Training materials used by BSSLC Abuse/Neglect classes April, 2012 15. Abuse/Neglect/Exploitation Competency Exam updated 8/1/12 16. List of Department of Family and Protective Services (DFPS) cases 3/1/13 to 8/31/13 17. List of Office of Inspector General (OIG) cases 4/1/13 to 8/26/13 18. List of serious injuries 3/1/13 to 8/31/13 19. List of other serious incidents 3/1/13 to 8/31/13 20. List of witnessed injuries 4/1/13 to 9/30/13 21. List of discovered injuries 4/1/13 to 9/30/13 22. Sample D.1 included a random sample of 15 DFPS investigations of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports. This sample was selected from the document the Facility submitted listing the allegations/investigations completed over the last six months. The sample was 23% of reported investigations initiated and completed over the last six months, and included DFPS investigations 42833517, 42817846, 42813513, 42797674, 42791746, 42780321, 42767503, 42758412, 42749843, 42743121, 42733130, 42726192, 42707629, 42700293, and 42696247. Review of this sample included review of personnel and programmatic recommendations made as a result of UIR Committee and IMRT recommendations. Seven of these 15 cases were also investigated by OIG. 23. Sample D.2 included a sample of seven Facility-only investigation reports selected from the document the Facility provided listing investigations completed over the last six months. The sample was 20% of reported investigations initiated and completed since the last visit and included UIR's 157, 104, 099, 123, 078, 130, and 095. Review of this sample included review of personnel and programmatic recommendations made as a result of UIR Committee and IMRT recommendations.

	24. Sample D.3: a subsample of Section F sample of nine Individual Support Plans (ISPs) 25. Other DFPS case reports: 42396346, 42688311, 42816276, and 42839252 26. Other UIRs: 090, 106, 108, 125, 143, and 150 27. BSSLC Investigator Recommendation Log 10/9/13 28. Injury review documents for ten reviews done by the Facility for its self-assessment. Individuals #172, #568, #53, #370, #61, #431, #297, #546, #446, and #238 29. Incident Management Team meeting minutes 6/10, 6/17, 6/24, 7/1, 7/8, 7/15, 7/22, 7/29, 8/5, 8/12, 8/19, and 8/26/13 30. QAQI Council minutes May through September, 2013 31. List of the ten most injured individuals since the last review 32. List of peers who caused the most injuries since the last review 33. BSSLC Unusual Incident Trend Report 9/30/13 34. BSSLC Abuse, Neglect, Exploitation Trend Report 9/30/13 35. BSSLC Injury Trend Report 9/30/13 36. Training transcripts for Facility Investigators 37. Training transcripts for DFPS Investigators 38. Minutes of DFPS/OIG/BSSLC meeting 6/5/13 39. Minutes of Self-Advocacy group 4/15, 5/20, and 6/24/13 40. List of BSSLC employees 9/5/13 41. DADS spreadsheet documenting background checks 9/9/13 42. DADS report MHMR0102 Percent of All Employees Completing Course of Training 9/5/13 43. Course/Due Delinquent reports for ABU0100 and UNU010 9/5/13 44. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes for all meetings since the last review **People Interviewed:** 1. Natalie Montalvo, Facility Director 2. Kim Littleton, Assistant Director of Programs 3. Daniel Dickson, Quality Assurance (QA) Director 4. Michael Appling, Incident Management Coordinator 5. D'eandra Polk, Facility Investigator **Meetings Attended/Observations**: 1. Incident Management Review Team (IMRT) Meeting 10/9 and 10/10/13 2. Quality Assurance Quality Improvement (QAQI) Council meeting 10/9/13 3. Unusual Incident Report (UIR) Committee 10/9/13 1.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section D, in conducting its self-assessment, the Facility: ▪ Did not use monitoring/auditing tools. The Facility had not been using any monitoring tool for

	Section D. The Incident Management Coordinator (IMC) reported he reviewed policies to ensure they cover the requirements of the SA. The IMC reported he conducted a 100% review of all investigation documentation. There was not any external validation of these reviews by the QA department. ▪ In some cases, used sampling to validate compliance, for example completion of required training classes. ▪ Used other relevant data sources such as computer generated tracking logs and staff training transcripts. ▪ The Facility presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Where appropriate, presented findings based on specific, measurable indicators. For example, it compared the number of investigations completed within the required timeframe with the total number of investigations. Nearly all calculated compliance scores were 100% or near 100%; therefore, there was little discussion of the areas of strength, weakness, or the status of progress. o For the most part did not measure, when appropriate, the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the incident management office because the QA Department did not independently conduct any self-assessment activity for Section D. ▪ The Facility rated itself as being in compliance with all 22 Provisions of Section D. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with 18 Provisions. Four Provisions rated as in compliance by the Facility self-assessment were determined to be noncompliant by the Monitoring Team. These were: 1. Provision D.2.a, which addresses timely reporting requirements. 2. Provision D.2.i which addresses injury audits 3. Provision D.3.f, which addresses investigation report content. 4. Provision D.3.g, which addresses Facility review of investigation reports Some of the inconsistencies resulted from sampled data showing different levels of compliance than self-assessment data. In other instances the level of analysis reflected in the self-assessment was insufficient or inconsistent with analysis conducted by the Monitoring Team. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Actions were reported, for the most part, as maintenance of current activity to maintain compliance in Provisions that had been reported as being in compliance. For those Provisions determined to be in noncompliance by the Monitoring Team the Facility will need to examine its Action Plan and make appropriate modifications.
	Summary of Monitor's Assessment: The Facility continued to make progress in achieving substantial compliance with Section D. In its last report the Monitoring Team reported compliance with 16 Provisions. Based on this review the Facility was

	in compliance with 18 (of 22) Provisions (82%). In its last review the Monitoring Team reported that the Facility did not have a Facility-specific policy on Abuse/Neglect or Incident Management. This had been corrected and the Facility now has a comprehensive policy addressing these topics. Since the last review the Facility experienced a significant increase in the number of allegations of abuse and neglect (55 to 122 when comparing six -month periods) and in confirmed findings (one to 14 when comparing six-month periods). The Facility continued to make improvements in the processes associated with the conduct of Facility investigations of serious incidents and the Facility review of non-serious discovered injuries (to rule out abuse/neglect). The Facility also continued to make improvements in the processes associated with the conduct of its review of DFPS investigations. Nevertheless, the Monitoring Team in its review of investigations identified investigation issues which were not identified by the Facility review process. The Facility had not demonstrated consistent reporting of allegations and serious incidents within the timeframes required by policy and by the Settlement Agreement. Alleged perpetrators were consistently removed from direct contact with individuals immediately following the Facility being informed of an allegation. Allegations of abuse/neglect were appropriately referred to law enforcement. Based on responses to questions about reporting abuse and neglect, 10 direct support professionals provided satisfactory answers with 63% accuracy when asked to describe the reporting procedures for abuse, neglect, and/or exploitation. This was an improvement from the 37% reported in the last review. Investigations commenced within 24 hours of the incident being reported; however, the completion of investigations did not always occur within 10 days. Extension requests did not always describe "extraordinary circumstances" (as required by the Settlement Agreement), sometimes describing only overall workload issues. Investigation reports did not always provide a clear basis for the investigation conclusion, sometimes not considering all available evidence. Recommendations coming from the Facility's investigation review process were tracked and recorded in a database until satisfactory evidence was provided to the IMC and reviewed by the Facility's UIR Committee and Incident Management Review Team. The scope of the tracking and trending of incidents and injuries, and the analysis of these data, had significantly improved since the last review.

	The staff training requirements associated with this section of the Settlement Agreement were up-to-date. Investigation files were well organized. Employee and volunteer background checks had occurred as required by policy.

#	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.	In its last review the Monitoring Team reported that the Facility did not have a Facility-specific policy on Abuse/Neglect or Incident Management. This has been corrected and the Facility now has a comprehensive policy addressing each topic. These policies include all provisions of the companion State policies. The Facility's policies and procedures did: 1. Include a commitment that abuse and neglect of individuals will not be tolerated, 2. 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 appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect, as illustrated by examples provided throughout Section D of this report. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. The relevant Facility policies were effective 5/1/13. Because of the Facility's high level of compliance with Section D Provisions, their implementation of the DADS statewide policy, and their initiation of a facility-specific policy, the Monitoring Team is satisfied the Facility had been operating within acceptable policy parameters. Implementation of these policies on a day to day basis is monitored throughout the remaining items of Section D of this report. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>D2</td><td>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:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.

According to data the Facility provided in a report prepared for the Monitoring Team, the number of Individuals involved in abuse/neglect/exploitation allegations for the past two six-month periods were:

<table>
<tr><th></th><th>9/1/12 to 2/28/13</th><th>3/1/13 to 8/31/13</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Total abuse allegations</td><td>38</td><td>71</td></tr>
<tr><td>Physical</td><td>33</td><td>54</td></tr>
<tr><td>Verbal/Emotional</td><td>5</td><td>17</td></tr>
<tr><td>Abuse substantiated</td><td>1</td><td>10</td></tr>
<tr><td>Physical</td><td>1</td><td>9</td></tr>
<tr><td>Verbal/Emotional</td><td>0</td><td>1</td></tr>
<tr><td>Abuse inconclusive</td><td>1</td><td>4</td></tr>
<tr><td>Physical</td><td>1</td><td>2</td></tr>
<tr><td>Verbal/Emotional</td><td>0</td><td>2</td></tr>
<tr><td>Total neglect allegations</td><td>17</td><td>51</td></tr>
<tr><td>Neglect substantiated</td><td>0</td><td>4</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Neglect inconclusive	0	2
Total exploitation allegations	0	2
Exploitation substantiated	0	0
Exploitation inconclusive	0	0

The Facility attributed the large increase in the number of allegations to improved staff awareness resulting from improved staff training, especially in New Employee Orientation. The Facility also reported it had taken steps to ensure staff with personal relationships outside the Facility was not assigned to the same work location.

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According to data the Facility provided in a report prepared for the Monitoring Team, the numbers of other unusual incidents for the past two six month periods were:

	9/1/12 to 2/28/13	3/1/13 to 8/31/13
Deaths	5	4
Serious Injuries	30	31
Sexual Incidents	2	4
Suicide Threat (credible)	1	3
Unauthorized Departure	4	4
Choking	3	2
Other	0	1

Based on the Monitoring Teams' review of DADS revised policies, including Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy 002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

According to the Facility policy Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1), staff were required to report suspected abuse, neglect, and exploitation within one hour by calling the DFPS 1-800 number. This was consistent with the Settlement Agreement requirements.

With regard to unusual/serious incidents, the Facility policy entitled Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) required staff to report unusual/serious incidents within one hour of discovery to the Facility Director/designee. This policy was consistent with the Settlement Agreement requirements.

#	Provision	Assessment of Status	Compliance
		In order to evaluate staff knowledge in the area of abuse and neglect reporting, 10 Direct Care Professionals were asked a series of questions. The 10 staff were selected by the Monitoring Team and included both am and pm staff. Each response was evaluated by one member of the Monitoring Team, the Facility's Incident Management Coordinator, and the Facility's Quality Assurance Director. Consequently, for each question, responses were subjected to 30 evaluations (ten staff times' three raters). Based on responses to questions, the 10 direct support professionals provided satisfactory responses to the following questions as noted: "Describe the reporting procedure and timeframe when abuse/neglect is suspected." Nineteen of 30 responses were evaluated as satisfactory (63%). This was an improvement from the 37% reported from the last review "Describe the reporting procedure and timeframe for other serious incidents." Eight of 30 responses were evaluated as satisfactory (27%). This was identical to the 27% reported from the last review. "Describe two signs or symptoms of abuse." Twenty-two of 30 responses were evaluated as satisfactory (73%). This was an improvement from the 50% reported from the last review. "Describe two signs or symptoms of neglect." Twenty-one of 30 responses were evaluated as satisfactory (70%). This was an improvement from the 40% reported from the last review. The above data suggests staff is not retaining information learned in formal training classes and may contribute to the problem the Facility identified in its self-assessment (and confirmed by the Monitoring Team) of late reporting. Based on a review of the 15 investigation reports included in Sample D.1: ▪ Five identified a date and time of the alleged incident. Two (40%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. Thus, twelve (80%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy or the date and time of the alleged incident was not known. Those that did not included UIRs 126, 118, and 090. ▪ Fifteen (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ For the three allegations for which staff did not follow the IM Policy and	

#	Provision	Assessment of Status	Compliance
		Reporting Matrix reporting procedures, one UIR (33%) included recommendations for corrective actions. This was UIR 090. Separate from the Monitoring Team review of Sample D.1 the Facility reported that it had identified, through the normal course of investigation reviews, three instances of untimely reporting. In each case appropriate administrative follow-up occurred. Based on a review of seven investigation reports included in Sample D.2: ▪ Six (86%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. UIR 123 did not. ▪ Seven (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. ▪ For the one unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIR included recommendations for corrective actions. The Facility had a standardized reporting format which meets generally accepted standards in that it contains information necessary for adequate follow-up as well as tracking and trending of incidents. Based on a review of 22 investigation reports included in Samples D.1 and D.2, 22 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. Based on this review the Monitoring Team determined this Provision was not in compliance. Late reporting of allegations of abuse and neglect remains a problem at the Facility, as reporting was not timely for 60% of sampled allegations for which date and time of incident were known..	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) the Facility was required to immediately remove any alleged perpetrator of abuse or neglect from contact with Individuals, placing the effected staff in NDC (no direct contact) status. Additionally, the Facility was to take immediate steps with the affected Individuals such as a nursing assessment and an emotional assessment. Based on a review of 15 investigation reports included in Sample D.1, 100% of alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. Based on a review of 15 investigation files included in Sample D.1 no staff placed in No	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	Direct Contact (NDC) status were returned to regular status until the completion of the investigation and after review disposition by the Facility UIR Committee and IMRT. Based on a review of 15 of the above documents, it was documented that adequate additional action was taken to protect individuals in 15 cases (100%). Actions included, for example, medical care, reassignment of roommates, and immediate training for staff. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) the Facility required that all staff complete the Abuse/Neglect training class ABU0100 annually. This was consistent with the requirements of the Settlement Agreement. Training curricula related to abuse and neglect were reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: ▪ In relation to the requirement that training be competency-based, testing provided at the completion of training classes validated staff competency in understanding the definitions of abuse, neglect, and exploitation; and, reporting requirements. ▪ The training did provide adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 24 staff records (Sample C.2), showed that 24 (100%) of these staff had completed competency-based training on abuse and neglect as part of New Employee Orientation and therefore prior to working directly with individuals. Review of DADS computer reports displaying the percentage of completion for training classes showed that 99% were current in completing abuse and neglect training. As reported in Provision D.2.a staff knowledge of abuse/neglect reporting responsibilities was variable. This may suggest the effectiveness of the training should be further probed by the Facility through quality assurance monitoring. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) staff are notified of abuse/neglect reporting responsibilities and must sign an acknowledgment form. This is Form 1020. Copies were requested of the forms for staff hired during the two full months prior to the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	on-site review. Based on a review of those forms 100% of staff hired during this time period had signed the acknowledgement form. A sample of 24 staff (Sample C.2) was randomly selected to determine if annual acknowledgements had been signed. Of these, 24 (100%) had signed annual acknowledgments. The Facility was asked for a list of staff that had been identified as having failed to report abuse and/or neglect. This generated a list of three instances of failure to report. Staff training and appropriate personnel actions related to these failures were taken. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual 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.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) IDTs were to provide LARs with written communication on abuse/neglect identification and the reporting process. Additionally, this topic is to be a regular point of discussion at each Individual's ISP meeting. A review was conducted of the materials to be used educate individuals. Materials included necessary information and were easy to understand and available in English and Spanish language versions. A review was conducted of the materials to be used to educate legally authorized representatives (LARs) or others significantly involved in the individual's life. Materials were easy to understand and available in English and Spanish language versions. The Monitoring Team review of ISPs associated with other Sections of the Settlement Agreement (SA) confirmed that there was a consistent method of documenting in the annual ISP the education of the LAR and individual on identifying and reporting ANE. The ISP template includes this topic to ensure it is covered in each ISP meeting. Based on a review of nine individuals' ISPs (Sample D.3), nine (100%) individuals, and/or their LAR and/or other significantly involved individuals had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. The ISP template includes a section addressing this topic. Finally, the Monitoring Team reviewed minutes of the three meetings of the self-advocacy group which had been held since the last review. All three included discussion of rights and/or abuse/neglect. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) postings directed at compliance with this requirement are to be maintained at all times. A review was completed of the posting the Facility used. It did include a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. The poster is available in both Spanish and English language. Observations by the Monitoring Team of 12 of 24 living units and day programs on campus showed that 12 (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The Facility reported it had on ongoing surveillance process that ensures the presence of posters is maintained. At the time of the review this process was informal and the Facility was unable to provide any documentation to validate its existence. The Facility will need to formalize this process and include it (and reports) in its regular QA program. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) allegations of abuse/neglect are to be reported, as appropriate, to law enforcement. Based on a review of 15 allegation investigations completed by DFPS (Sample D.1), DFPS had made law enforcement (OIG) referrals in all 15 (100%). Based on a review of seven investigations completed by the Facility (Samples D.2), in none was a referral to law enforcement necessary or appropriate. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands,	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) retaliation against reporters of abuse/neglect was prohibited and not tolerated. The Facility has an additional policy addressing this subject: D.5 Prohibition Against Retaliatory Action. Ten staff was asked "If you reported abuse or neglect would you worry about being retaliated against by a coworker or supervisor." Eight (80%) responded "no".	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Based on interviews with the Facility Director and Assistant Director of Programs (ADOP), the prohibition against retaliation and the consequences associated with retaliation are included in training curriculum and re-enforced using postings throughout the facility. Each stated emphatically that retaliation is not tolerated and when alleged or detected was formally investigated. Since the last review there were two incidents that included suspicion of retaliation. Both were reported to OIG for investigation. In each case OIG did not substantiate retaliation. Nevertheless, the Assistant Director of Programs met with each employee and mutually developed supports to make each employee as comfortable as possible, including cellphone access to the ADOP to immediately report any problem and an escort to their car at the end of shift (10pm). Based on a review of investigation records (Samples D.1 and D.2), there were not concerns noted related to potential retaliation. Outside investigators (DFPS/OIG) were not onsite during the week of this review and were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with retaliation. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Facility policy (DD.2) defined sufficient procedures to audit whether significant injuries are reported for investigation. This policy had an effective date of 8/24/13. At the time of the review by the Monitoring Team no audits pursuant to this policy had been done.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The	Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) described in a comprehensive fashion of the conduct of all	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	such investigations; required that investigators be qualified requiring that Investigators complete training in Comprehensive Investigator Training (CIT0100), People with MR (MEN0300), Conducting Serious Incident Investigations (CSI0100), and, a class in Root Cause Analysis; and required that investigators be outside of the direct line of supervision of the alleged perpetrator. Training curricula were reviewed for Department of Family and Protective Services (DFPS) and Facility investigators. This review of material used by DFPS in training its investigators revealed the following: The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules the Monitoring Team is of the opinion that this training is competency-based and meets the requirements of the SA. DADS policy reported that Facility Investigator training is to consist of the following classes: 1. ABU0100 Abuse and Neglect 2. UNU0100 Unusual Incidents 3. MEN0300 People with Mental Retardation 4. CIT0100 Comprehensive Investigator Training, or LRA training Conducting Serious Investigations	

#	Provision	Assessment of Status	Compliance
		5. Root Cause Analysis The Monitoring Team believes this training, if completed as described, was adequate for the conduct of investigations at BSSLC, was competency based, and meets the requirements of the SA. The training records for DFPS investigators were reviewed with the following results: ▪ Three of three DFPS investigators (100%) had completed the requirements for investigations training. ▪ Three of three DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The training records for Facility investigators were reviewed with the following results: ▪ Five of six Facility investigators (83%) had completed the requirements for investigations training. The sixth investigator was new and had not as yet taken the Conducting Serious Investigations and Root Cause Analysis class but was scheduled to do so. This investigator had not been assigned cases. ▪ Six of six Facility investigators (100%) had completed the requirements for training regarding working with individuals with developmental disabilities. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) Facility staff were required to cooperate with outside entities conducting investigations of abuse and neglect. As described above with regard to Section D.2.a of the Settlement Agreement, two samples of investigation files were selected for review. These included Samples D.1 and D.2, which consisted of DFPS investigations, and Facility investigations, respectively. Review of the investigation files in Sample D.1 showed that in 22 of 22 investigations (100%), Facility staff cooperated with DFPS investigators. Outside investigators (DFPS/OIG) were not onsite during the week of this review and were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with Facility cooperation. As an added measure to ensure inter-agency communication, the Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision. This meeting included both the Facility Director and the DFPS Supervisor who oversees investigations at the Facility.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Additionally, the Facility had made office space available to DFPS which is accessible 24/7. Based on this review the Monitoring Team determined this Provision was in 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 and the Facility, the following was found: ▪ Of the 15 investigation records from DFPS (Sample D.1), 15 had been referred to law enforcement (Office of Inspector General). For these 15 (100%) there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the seven investigation records from the Facility (Samples D.2), none had been referred to law enforcement agencies because none were appropriate for referral. Outside investigators (DFPS/OIG) were not onsite during the week of this review and were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with coordination of investigatory effort. As an added measure to ensure inter-agency communication, the Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) the Facility was required to preserve and secure physical evidence.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		While on site, the Monitoring Team observed the area the Facility uses for safeguarding physical evidence. This included a locked cabinet in the office of the Incident Management Coordinator. Physical evidence was placed in a paper bag and was identified as to content, collector, and date. The IMC office is also locked and only accessible to the IMC and his supervisor, the QA Director. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Samples D.2): ▪ Physical evidence that needed to be safeguarded was safeguarded in all DFPS investigations; and ▪ Physical evidence that needed to be safeguarded was safeguarded in all Facility investigations. Outside investigators (DFPS/OIG) were not onsite during the week of this review and were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with protection of physical evidence. State Policy 021.2 (and reiterated in Facility Policy D.1) states "the facility investigator should prioritize the collection of evidence that is most at risk of contamination. In most cases, the highest priority will be to identify interviewees and physically separate them until they have interviewed." Evidence gathered through interview is considered testimonial evidence. The Monitoring Team found no evidence that would suggest this component of the DADS policy (separation of witnesses until they are interviewed) was being followed. In reviewing Sample D.1 (DFPS investigations) there was no indication that interviewees had been physically separated pending interview. As a practical matter this would be difficult since DFPS rarely began interviews of collateral witnesses or alleged perpetrators (AP) until several days after the allegation was reported. Staff interviews for Sample D.1 did not begin until at least the fifth day after the reported incident in eight of 15 (53%) cases. In one case, staff interviews did not begin until 13 days after the reported incident. DADS should review its policy with respect to testimonial evidence and provide guidance to Facility's as to how it should be implemented. When an AP is placed on No Direct Care (NDC) status they sign an acknowledgment statement that includes, among other things, the following statement: "You are not to discuss the allegations or details of the investigation with anyone other than the investigators." In abuse/neglect training, and unusual incident training, staff is instructed to not discuss with each other any information regarding incidents under investigation. The Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision.	

#	Provision	Assessment of Status	Compliance
		Based on this review the Monitoring Team determined this Provision was in 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.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Did require a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed and approved outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Samples D.2) 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 Sample D.1 DFPS investigations: Fifteen out of 15 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. Typical activity reported in investigation reports included: • Telephone contact with the Facility's Incident Management Coordinator or Campus Coordinator to ensure the Individual who is the subject of the report is safe (and if injured has received appropriate medical care). • Checking to assure that any known APs were placed in NDC status, • The identification of any collateral witnesses, • Validation that the Facility has (or is) gathering all relevant documentation, • Validation that any physical evidence is secure, • A determination that there is or is not likely video surveillance evidence to review, • The development and review of a preliminary investigation plan. Commencement of interviews with collateral witnesses and AP's is not required to occur within 24 hours except for Class I allegations. In some cases the time delay in beginning	Substantial Compliance

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		staff interviews was extraordinary and could have affected the accuracy of testimonial evidence. For example, in reviewing Sample D.1 the Monitoring Team determined that the first staff interview did not occur until at least five days after the allegation was reported in eight of 15 cases (53%). In one case (42700293) the first staff interview by DFPS did not occur until the 13th day after the allegation was reported. Ten of 15 (67%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; for the five that were not completed within 10 days, all had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. The extraordinary circumstance that necessitated the extension for 42743121 was "investigator did not begin investigation until 10th day and was unable to complete it". This was not an acceptable justification for an extraordinary circumstance. If there was an extraordinary circumstance (other than workload) that prevented the assigned investigator from beginning the investigation, or having the investigation assigned to a different investigator, that should have been documented. Fourteen of 15 (93%) investigations were completed within 10 days or had an acceptable approved extension request. Fifteen (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. None of the investigations reviewed (0%) included recommendations for corrective action. In eight of the investigations (53%), concerns were noted regarding Facility practices that should be addressed. Because these were not stated in the form of recommendations the Monitoring Team cannot determine if addressing the concerns would be adequate to address issues related to the findings of the investigation. It may be helpful to the Facility if DFPS reports were to contain specific recommendations, where appropriate, rather than merely reporting concerns. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: Seven out of seven (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the Unusual Incident Report (UIR) that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified or becoming aware of the serious incident. The Facility had modified the UIR template to clearly describe commencement timeframes and work activity.	

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		Seven out of seven (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. Seven (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In seven of the investigations reviewed, recommendations for corrective action were included. In seven of the investigations (100%), the recommendations were adequate to address the findings of the investigation. Based on this review the Monitoring Team determined this Provision was in substantial compliance	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the	Based on the Monitoring Teams' review of DADS revised Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. Investigation files maintained by the Facility were well organized. Each file contained 23 tabs which identified content of each tab and organized relevant material. Each file included a "BSSLC Filing System for Unusual Incident Investigations" cover sheet which served as a table of contents for the file, and a checklist recording the presence of required documents in the file. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In 12 of 15 investigations reviewed (80%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Those that did not were: Unconfirmed Physical Abuse 42817846 and 42758412 and Unconfirmed Neglect 42707629. • Unconfirmed Physical Abuse 42817846. This investigation was not thorough. The injury report documents multiple injuries (13). Investigation interviews reported that staff had little or no knowledge of cause. Video review (which did not occur) could have either helped determine a cause for some of the injuries, or, at least corroborated some of the testimonial evidence. The language in the "Probable Version of Events" section of the investigation report states "increase in behavior over the last few months could explain the new bruising." In as	Noncompliance

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	alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	much as this was an allegation of physical abuse it appears an inconclusive disposition may have been more appropriate than an unconfirmed disposition. • Unconfirmed Physical Abuse 42758412. This investigation was not thorough. The allegation refers to "black eyes and bruised mouth." The injury report completed by a Facility nurse documents multiple abrasions to the upper and lower back (but not any black eye or bruised mouth). The investigation did not attempt to reconcile this conflicting information or try and determine if these injuries were in anyway related to the alleged abuse being investigated. The investigation did not establish a timeline, i.e. when the Individual was last observed without the injury and when first observed with the injury. Had this occurred staff interviews and video review could have been much more targeted to the timeframe immediately preceding when the injuries, whatever they were, occurred. Finally, the lack of staff insight as to how the injuries occurred (other than conjecture) did not appear to be of concern to the investigator. The only "concern/recommendation" noted in the investigation report concerned a mattress cover which had nothing to do with the allegation, probable version of events, or conclusion. • Unconfirmed Neglect 42707629. This investigation was not thorough. This Individual was on 1:1 supervision from 6am to 10pm and enhanced supervision from 10pm to 6am. In reviewing the investigation report it was not possible for the Monitoring Team to determine if all staff assigned to supervise the Individual in the 48hrs prior to the discovery of the injury were interviewed. Additionally, no physician was consulted on the case to offer an opinion as to if the injury looked consistent with an injury that would occur as a result of the described behavior (masturbation) noted in the investigation report. Finally, no video was reviewed to determine if anyone (staff or others) entered the Individual's bedroom and could have engaged in any activity that could have caused the injury. • The report utilized a standardized format that set forth explicitly and separately: o In 15 (100%), each unusual/serious incident or allegations of wrongdoing; o In 15 (100%), the name(s) of all witnesses; o In 15 (100%), the name(s) of all alleged victims and perpetrators; o In 15 (100%), the names of all persons interviewed during the investigation; o In 15 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 15 (100%), all documents reviewed during the investigation; o In 12 (80%), all sources of evidence considered, including previous	

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		investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. Those that did not were: Unconfirmed Physical Abuse 42817846 and 42758412 and Unconfirmed Neglect 42707629(see above description); o In 15 (100%), the investigator's findings; and o In 15 (100%), the investigator's reasons for his/her conclusions. In addition to Sample D.1 the Monitoring Team reviewed case 42816276. This case was discovered in reviewing restraint information. This was an allegation of physical abuse with a disposition of unconfirmed. This incident was also investigated by OIG with an unsubstantiated finding. The substance of the case centered on whether the interactions between the alleged perpetrator and the alleged victim represented appropriate PMAB techniques, a crisis intervention restraint, or physical abuse. The alleged perpetrator received several injuries as a result of these interactions. The investigation relied heavily on video review but did not include consultation with any Facility clinical or training staff familiar with approved PMAB techniques and approved restraint procedures. When an investigation needs to assess, in part, the clinical practices used by staff (in this case attempted application of restraint and/or proper use of PMAB techniques) appropriately credentialed and/or trained Facility staff should be consulted. Additionally, the Facility review of this investigation did not identify this problem. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • In seven of seven investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o In seven (100%), each unusual/serious incident or allegations of wrongdoing; o In seven (100%), the name(s) of all witnesses; o In seven (100%), the name(s) of all alleged victims and perpetrators; o In seven (100%), the names of all persons interviewed during the investigation; o In seven (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 seven (100%), all documents reviewed during the investigation; o In seven (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In seven (100%), the investigator's findings; and o In seven (100%), the investigator's reasons for his/her conclusions.	

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		Based on this review the Monitoring Team determined this Provision was not in compliance because of issues associated with DFPS investigations. The Facility, in its review of DFPS investigations, must ensure the investigations are thorough, complete, timely, and reach appropriate conclusions.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The Facility policy and procedures required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. The Facility policy did require that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ The DFPS investigations in Sample D.1 did not meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) <u>and</u> D.3.f; ▪ Fifteen of 15 (100%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation. ▪ The Facility Director/Incident Management Coordinator did accept at least ninety-four percent of the investigations over the six months prior to the onsite review. ▪ For three of the DFPS investigation files (Sample D.1) the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. Based on a review of the Facility's data, for none of these three (0%), the Facility correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. The Facility had a very thorough process for reviewing DFPS investigation reports, including a UIR Committee which met twice a week. This committee also reviewed every facility investigation. The Committee consisted of the Facility Director, Assistant Director of Programs, the Incident Management Coordinator, the Quality Assurance Director, and the Independent Ombudsman. The Monitoring Team observed one meeting and was impressed with the thoroughness of review and discussion. From a review of meeting minutes it was clear that in most cases these reviews detected issues associated with the investigation under review. Facility review of DFPS investigations resulted in one being returned to DFPS for reconsideration of the disposition finding. DFPS changed the disposition from inconclusive to confirmed. In reviewing another DFPS investigation with an unconfirmed disposition the Facility Director changed (as is allowed by policy) the disposition to confirmed.	Noncompliance

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		Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ Seven of seven (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. ▪ In seven of seven investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ For four, the supervisor had identified concerns. For these investigations, for four (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. Based on this review the Monitoring Team determined this Provision was not in compliance. Three of 15 (20%) DFPS investigations (Sample D.1) reviewed were not thorough and complete and the Facility review of these investigations was inadequate. Facility review of DFPS case 42816276 (refer to Provision D.3.f) was also inadequate.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility-only investigations met the requirements outlined in Section D.3.f. Based on this review the Monitoring Team determined this Provision was in compliance.	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.	The Facility policy and procedures required disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. For all investigations reviewed in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented in each case. Based on a review of investigations for which recommendations for programmatic action were made, the following was found: ▪ For 22 of 22 investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented. ▪ For 22 out of 22 investigations (100%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The Facility maintained a UIR Tracking Log which described each recommendation made	Substantial Compliance

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		by the IMRT and UIR Review Committee, the person responsible for implementing, and the projected and actual completion dates. The IMC maintained a "BSSLC Investigator Recommendation Log" which tracked all recommendations through completion, including submittal to the IMC of evidence of completion. This log was reviewed daily at the IMRT meeting. The Facility provided the Monitoring Team with direct evidence of employee disciplinary action and programmatic actions to demonstrate compliance with this Provision. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(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.	According to Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) records of every investigation are to be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, electronic data systems were maintained which allowed the IMC to sort investigation records by name of the alleged perpetrator or by name of the alleged victim. The IMC reported that DFPS also has a data management system that allows a search of prior case history of alleged perpetrators and alleged victims. Additionally, DFPS, if necessary, can obtain these data from the Facility. For Facility investigations, these data are included in the UIR template which enables the Facility investigator to determine its relevance to each investigation. Based on this review the Monitoring Team determined this Provision was in compliance.	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.	For all categories of unusual incident categories and investigations, the Facility had a system that allowed tracking and trending by: • Type of incident; • Staff alleged to have caused the incident; • Individuals directly involved; • Location of incident; • Date and time of incident; • Cause(s) of incident; and • Outcome of investigation. Over the past two quarters, the Facility's trend analyses: • Were conducted at least quarterly; • Addressed the minimum data elements; • Used appropriate trend analysis procedures;	Substantial Compliance

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		• Provided a narrative description/explanation of the results and conclusions; and • Did, as appropriate, contain recommendations for corrective actions. Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified and an action plan was needed, action plans were developed. As appropriate, action plans were developed both for specific situations and at a systemic level. QAQI Council minutes showed that action plans were implemented and tracked to completion and addressed the effectiveness of previous action plans. In its last report the Monitoring Team noted that the Facility did not use its analysis of data collected pursuant to this provision to identify trends and identify apparent problems and issues that needed attention. Since the last review trend data on incidents and injuries is presented to each monthly meeting of the QAQI Council (rather than quarterly) providing that group information to permit it to more closely monitor abuse, neglect, and injury trends and determine trends which may suggest a need for corrective action planning. Based on this review the Monitoring Team determined this Provision was in substantial compliance.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and 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 State Office, the Director 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 24 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed through the review of documents provided to the Monitoring Team. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. All employees were subject to fingerprint checks during the month of October, 2010. Since then, new	Substantial Compliance

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	indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	hires have had fingerprint checks as part of their pre-employment screening. 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. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that the Facility Director maintained a log of instances where an employee did not self-report and initiated appropriate administrative/disciplinary action when this occurred. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility Based on this review the Monitoring Team determined this Provision was in substantial compliance.	

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment 9/23/13 2. BSSLC Action Plan 9/18/13 3. Section E Presentation Book (undated) 4. DADS Policy 003.2 Quality Assurance 5/22/13 5. BSSLC Policy E.1 Quality Assurance Process 6/1/13 6. BSSLC Policy E.2 Quality Assurance/Quality Improvement Council – scheduled for implementation 4/21/13 7. BSSLC Policy E.3 – Developing, Implementing, & Tracking Corrective Action Plans 5/24/12 8. BSSLC Quality Assurance Plan (including QA matrix) 8/30/13 9. Data List Inventory 8/31/13 10. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes for all meetings since the last review 11. QA/QI meeting agenda and meeting handouts 10/9/13 12. Facility Trend Reports 9/30/13 13. Monitoring tools **People Interviewed:** 1. Daniel Dickson, QA Director 2. Natalie Montalvo, Facility Director **Meetings Attended/Observations**: 1. QA/QI Council meeting 10/9/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment, the Facility reviewed minutes of the QA/QI Council, reviewed longitudinal data, reviewed the QA and CAP tracking policy, reviewed QA process established since the last review, and reviewed the Corrective Action Plan (CAP) tracking system. The Facility QA Department did not use any specific monitoring tools in assessing compliance with Section E. The Facility did not always present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment did not provide sufficient detail to determine the status of QA implementation by departments and disciplines. Rather, many statements in the self-assessment were general such as "data from monitoring tools for each department are reviewed with section lead/department head each month." This was an improvement from the last self-assessment which consisted largely of overly broad and generic statements such as "disciplines are currently in the developmental stage of internal QA monitoring processes, analysis, and corrective action planning." Additionally, the Facility's inter-rater reliability process was not fully implemented. While improved since the last review, the Facility was still in the early

	stages of implementing a comprehensive QA program and different departments/disciplines were at different stages of QA implementation. In the future, the QA self-assessment should be more detailed describing implementation status by department/discipline. The Facility did not rate itself as being in compliance with any provisions of Section E. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Action steps were for the most part general and were not targeted at specific actions for specific departments and disciplines at the Facility. Many stated "training staff" on QA policy or similar general statements rather than the specific administrative steps necessary to move towards compliance with Section E. The Facility believes this set of steps will likely lead to compliance with the requirements of this Section. All steps in the Action Plan are to be completed by 12/31/13. The Monitoring Team looks forward to assessing this compliance at its next review.
	Summary of Monitor's Assessment: In its last review the Monitoring Team reported that quality assurance activity necessary to achieve compliance with Section E of the Settlement Agreement was still in a formative stage. This is still largely the case. While the Facility had improved practices from that observed at the last review there were still many elements of the QA process that appear fragmented and not operating as a QA system. There were facility policies that adequately supported the state policy for quality assurance. These were not, however, consolidated in to one comprehensive QA policy. The QA plan narrative at the Facility was not complete and adequate. The QA plan matrix did not include all self-monitoring tools and self-monitoring procedures. The Facility had begun the process of developing key indicators and had drafted 14 quality indicators. There was not a complete and adequate data list/inventory at the Facility. The Facility reported it had begun the practice of having "benchmark meetings" between the QA Department, Section/discipline leads, and the SA Coordinator. Three such meetings had occurred. The Facility processes for initiating, implementing, and tracking CAPs had become slightly more organized than that observed the last review. There are still many improvements needed in CAP development, implementation, outcome monitoring, and related administrative systems. The Facility was struggling with the CAP process and the requirements of the SA associated with the CAP process. The entire QA process needs to mature and become administratively reliable in all areas (e.g. data collection, inter-rater reliability, data compilation, data review, use of data for problem identification, developing and implementing CAPs, and evaluating the effectiveness of CAPs).

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>State QA policy</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the Facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. The state policy called for a statewide QA/QI Council and for statewide discipline QA/QI committees. Neither was in place at this time. <u>Facility QA policies and practices</u> There were facility policies that adequately supported the state policy for quality assurance. These were not, however, consolidated in to one comprehensive QA policy. The Facility had a Quality Assurance/Quality Improvement (QA/QI) Council required by State policy. Additionally, some other Facility policies contained a QA component within them that complemented the over-arching Facility policy. There was not a complete and adequate data list/inventory at the Facility. The Facility had compiled a list of what it characterized as "most data" collected by the Facility. It included data related to quality assurance, active treatment, accounting, admissions, medical services, staff training, dental services, habilitation programs, human rights, incident management, records, nursing services, pharmacy services, psychiatry services, psychology services, QIDP services, and residential services. Within these categories, 165	Noncompliance

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		separate data reports were listed. The list was not complete. For example, data related to restraint was not included. The QA Director reported the creation of the data list/inventory is still a "work in progress" and once complete the Facility will work to determine how best to use this data (analyze) as part of the QA process. The inventory was maintained by the QA Director and was regularly reviewed. The QA plan narrative at the Facility was not complete and adequate. The plan narrative had been reviewed and updated 8/30/13. It included some, but not all, essential elements of a QA Plan. Essential elements of a QA Plan would include, at a minimum: ▪ a description of the purpose of the QA program, ▪ organizational structure of the QA process (including individual roles and responsibilities), ▪ data list/inventory, ▪ QA matrix, ▪ key indicators, ▪ how data are summarized and analyzed, ▪ role of other clinical and operational departments in QA, ▪ workgroups/PITs, ▪ the QA report, ▪ QA/QI Council and its role in reviewing data and guiding the entire QA process, and ▪ corrective actions/CAPs. Some of the information lacking in the QA Plan was contained in separate documents. The Facility needs to create a QA Plan that includes the components listed above. The QA plan matrix showed the data to be submitted to the QA department; these data are then intended to be included in QA reports and presented to the QA/QI Council. The QA Plan matrix showed that data for some sections of the SA had been suspended (Sections C and D) and for some parts of other sections had not as yet been implemented (significant injury monitoring, ISP attendance tracking, at-risk tracking, weight concerns, skin integrity issues, and pneumonia tracking). From review of QA/QI monthly reports and data provided by the QA Director, the Monitoring Team determined that for the 19 sections of the Settlement Agreement (not including Section E), an adequate set of key indicators were included for none of the 19 sections (0%). The Facility had completed an initial draft of Quality Indicators which was under review by Facility management. These 14 indicators addressed some Sections of the SA but in no case were they sufficient to address all provisions within each section. None included both process and outcome indicators.	

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		None indicated if key indicators would include analysis related to the specific requirements for Provision E1--trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services: areas of care; individual staff; and/or Individuals receiving services and supports, as necessary and appropriate to each key indicator. It was not clear if the Facility's data system had achieved a level of maturity such that multiple variables could be examined from many different data points. The 14 quality indicators presented to the Monitoring Team and under consideration by the Facility included: 1. Regulatory Trends – standard trend report produced monthly 2. ANE Trending – standard trend report produced monthly • # of allegations Neglect • # of confirmed cases of ANE • # of Unusual Incidents • # of Unusual Incidents resulting in injury 3. Unusual Incidents – standard trend report produced monthly • # of Unusual Incidents • # of Unusual Incidents resulting in injury • # of deaths 4. Client to client aggression – QA manually tabulates data and presents in graphical display • # of persons injured as a result of peer aggression • # of peer to peer aggression without injury 5. Injuries – standard trend report produced monthly • # of discovered injuries 6. Slip, Trips & Falls – QA manually tabulates data and presents in graphical display • # of falls resulting in injury • #of falls without injury 7. Restraints – standard trend report produced monthly • # of restraints • # of crisis intervention restraints • # of persons who required 4 or more restraints in a rolling 30 day period • # of persons who required 4 or more restraints in a rolling 30 day period with IDT review within 3 business days • # of chemical restraints • # of Dental restraints • # of Medical restraints 8. Pneumonia – Avatar data entry; beginning to aggregate and present graphical	

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		display • # of persons at high risk for aspiration • # of persons at high risk for respiratory compromise • # of persons diagnosed with pneumonia • # of persons diagnosed with aspiration pneumonia • # of persons diagnosed with pneumonia that are fed orally • # of persons diagnosed with pneumonia that are enterally fed 9. Skin Integrity – Database issues with tracking and trending • Skin Integrity database--no reports currently available 10. Medication Variances – Avatar entry; continuing to produce local database graphical reports • Medication Variances Report (this will be completed quarterly) 11. Immunizations – Avatar data entry beginning to aggregate and present graphical display • # of persons current on immunizations 12. Infection Control – Avatar data entry; beginning to aggregate and present graphical display • Infection Control Database reports 13. Hospitalization Trending - Avatar data entry; beginning to aggregate and present graphical display 14. Re-evaluation for Enteral Feeding –beginning to aggregate and present data • # of persons with enteral nutrition • # of persons who have returned to oral presentation Nearly all of what was presented above represented keeping counts of various events and not measuring processes or outcomes. The Facility acknowledged they at the very beginning stages of developing a program and procedures that can fully address this. The QA plan matrix did not include all self-monitoring tools and self-monitoring procedures. For example, the matrix showed that use of the State Section C and D monitoring tool had been suspended; however, it was reported to the Monitoring Team that an alternative facility-specific monitoring tool (refer to Provision C.8) had been in use. This was not reflected on the Quality Assurance Plan Matrix. Data listed on the QA Plan matrix that was to be collected by QA staff members was apparently very limited. The Monitoring Team could not determine from reviewing the plan matrix what data, if any, was collected by the QA Department. Because the QA data list/inventory was essentially a draft work in progress the Monitoring Team could not see if data items were also included in the plan matrix.	

#	Provision	Assessment of Status	Compliance
		The QA Plan Matrix identified 43 data items that were expected to be routinely reported to the QA Department. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that of the 43 items in the QA plan matrix, 30 (70%) were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). Of the 43 items in the QA plan matrix, 30 (70%) were documented to show review or analysis by the QA department and/or the department section leaders for the last two reporting periods for each item (e.g., monthly, quarterly). At the time of the review, of the 43 components of the QA plan narrative and QA plan matrix, the Facility implemented 30 (70%). The Facility reported it had initiated "benchmark meetings" between the QA Department, Section/discipline leads, and the SA Coordinator. Three meetings occurred since the last review and covered Provisions F, I, O, P, R, and T. The purpose of these intended monthly meetings, as articulated in the QA Plan narrative, was to review monitoring data and determine what recommendations, if any, should be presented to the QA/QI Council. Five of 19 Sections of the SA (not including Section E) included a benchmark meeting in the last six months (26%). Consistent implementation of monthly benchmark meetings was not occurring. Of the 16 self-monitoring tools for the SA, the content of 16 (100%) appeared to be appropriate and the QA Director reported 16 (100%) were reviewed within the past six months, and revised as appropriate. Much of this occurred in the context of updating the QA plan in August. Sections D, E, Q, and H did not have self-monitoring tools. The Facility reported all 16 self-monitoring tools had adequate formal instructions and guidelines for the user; however, the Section Lead for Section C reported, in reviewing compliance with Provision C.8, that she had not as yet written instructions for the Monitoring Tool used for Section C. The Monitoring Team was unable to reconcile this conflicting information. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that since the last onsite review, of the self-monitoring tools for the 19 sections of the SA (one is not expected for Section E), 16 (84%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-rater reliability). Those that did not (Sections D, Q, and H) have not as yet implemented monitoring tools. From review of QA/QI monthly reports and interview with the QA Director the	

#	Provision	Assessment of Status	Compliance
		Monitoring Team determined that since the last onsite review, of the 19 sections of the SA, there was documentation that the implementation (not including interobserver agreement which was described by the Facility as needing improvement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for 16 (84%) of the 19 sections. Those that did not (Sections D, Q, and H) have not as yet implemented monitoring tools. Based on this review this Provision was not in compliance. While the Facility had improved practices from that observed at the last review there are still many elements of the QA process that appear fragmented and not operating as a QA system.	
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.	All data in the QA plan matrix should be summarized, graphed, and analyzed by discipline department with oversight and assistance as needed by the QA department. Data from the QA plan matrix for 19 of the 19 (100%) sections of the SA (not section E) were summarized, graphed showing trends over time, and analyzed across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as appropriate to the indicator being measured. Not all of this data was derived from Monitoring Tools. Sections D, Q, and H did not use Monitoring Tools. Not all data measured performance; some counted events, such as the number of hospitalizations. Not all relevant data was trended longitudinally. For example, the Facility Restraint Trend Report did not trend restraint use by shift or day of the week longitudinally. Longitudinal trending could be helpful in identifying variables (such as a shift or a day of the week) requiring increased administrative and clinical attention. Not all Sections of the SA had been monitored longer than six months (three of 19 had not – 16%) and as reported in Provision E.1 many aspects of the QA plan, primarily related to key indicators, were not yet fully defined and implemented. Therefore, not all monitored elements of some of the sections of the SA had been used long enough to permit assessment of trends. Since the last onsite review, a meeting occurred between discipline/department staff and QA staff at least twice for 10 of the 19 (53%) sections of the SA. These meetings: • Did not include a review of the data listing inventory and matrix, • Included discussion of data and apparent outcomes, • Included a review of the conduct of the self-monitoring tools, • Included discussion of the need to create corrective action plans as appropriate, • Included a review of previous corrective action plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Since the last onsite review, data were available during these meetings to facilitate department/discipline review and analysis with QA staff; however, as noted above, the Facility reported that 16 of 19 (84%) of the monitoring tools used by the Facility had been in place for longer than six months and many aspects of the QA plan were not fully operational. As a result in some areas there was not sufficient longitudinal data available to permit meaningful review and analysis. Since the last onsite review, the Facility had initiated five Corrective Action Plans (CAPs). The origin of each CAP was not clear. It could not be determined which CAPs resulted from review and analysis of data at a discipline/department meeting, at a discipline/department meeting that included QA staff, by QA staff, or as a result of a recommendation at a QA/QI Council meeting. One purpose of regularly scheduled data reviews by QA staff with discipline/department staff is to identify trends and other conditions that signal a need for initiation of a CAP. In the future, CAPs should note the origin. It was clear that at some point all five CAPs were presented to the QA/QI Council. Since the last onsite review, a facility QA report (for dissemination at the Facility and for presentation to the QA/QI Council) was created for five of six months (83%). The August report did not occur because of a major survey at the Facility. These data were incorporated in the September report. Of the 20 sections of the SA, 16 (80%) appeared in a QA report at least once in each quarter since the last onsite review. As reported by the Facility, Sections Q, G, #, and H did not appear in the QA report as there was not an adequate monitoring process for these sections. Of the 16 sections of the SA that were presented at the QA/QI Council: • All contained self-monitoring data. • None reported key indicator data (this was a relatively new process at the Facility). • All contained narrative analysis, although in many cases what was labeled as "analysis" was more of an explanation of the data rather than an analysis of how one might interpret the data. There was an adequate description of the QA/QI Council in the QA plan narrative and in a separate QA/QI Council policy or procedure document. Since the last onsite review, the QA/QI Council met at least once each month with the exception of August 2013. QA data that would ordinarily have been discussed at the August meeting was included in the September meeting.	

#	Provision	Assessment of Status	Compliance
		Agendas were structured so that each Section of the SA was reviewed at least once every three months. Minutes from all QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, Minutes from all QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes from all QA/QI Council meetings since the last review documented that (a) data from QA plan matrix were presented, (b) for the most part the data presented were trended over time, (c) comments, interpretation, and/or analysis of data were presented. As reported in Provision E.1 some Monitoring Tools had not been in use long enough to permit meaningful review of longitudinal data. In each QA/QI Council meeting recommendations and action plans were selected when appropriate to do so, and were based on the data presented. During a QA/QI Council meeting observed by the Monitoring Team, there was active and appropriate participation of attendees other than the presenter for six of the six (100%) reports/data presented during the meeting. A spirit of teamwork was evident to the Monitoring Team. The Facility processes for initiating, implementing, and tracking CAPs had become slightly more organized than that observed the last review. There are still many improvements needed in CAP development, implementation, outcome monitoring, and related administrative systems. The Facility had a specific policy on developing, implementing, and tracking corrective action plans. It did not include specific criteria for the development of a CAP such as when monitoring data showed performance indicators were not at, or had dropped below, a pre-determined threshold (for example, 85%). This was likely because the Facility monitoring process has not as yet fully matured and was not considered to produce enough reliable data to have absolute benchmarks for CAP initiation. Of the 5 CAPs reviewed by the Monitoring Team, 5 (100%) appeared to appropriately address the specific problem for which they were created. These five CAPs addressed: 1. The use of pre-treatment sedation. 2. Program monitoring. 3. Addressing change in status.	

#	Provision	Assessment of Status	Compliance
		4. Psychiatric referrals 5. Pneumonia occurrences In reviewing these five CAPs the Monitoring Team found the following: • Four (80%) included the actions to be taken to remedy and/or prevent the reoccurrence. • Three (60%) included the anticipated outcome of each action step. • Five (100%) included the person(s) responsible. • Five (100%) included the time frame in which each action step must occur. Based on this review this Provision was not in substantial compliance. Progress had occurred since the last review but full and complete implementation of data collection, review, and analysis (including inter-rater reliability) had not as yet been achieved.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	In reviewing the five CAPs that the Facility had in process the Monitoring Team determined that: (a) None (0 %) included documentation about how the CAP was disseminated (b) None (0 %) included documentation of when each CAP was disseminated, and (c) Five (100 %) included documentation of to whom it was disseminated, including specific person(s) responsible. Based on this review the Monitoring Team determined this Provision was not in compliance.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The Facility QA Director reported that the Facility was struggling with the CAP process and the requirements of the SA associated with the CAP process. Based on a sample of three completed CAPs and two in process CAPs, none (0%) were implemented fully and none (0%) were implemented in a timely manner. "Fully" means that all steps of the CAP were implemented, and there was complete implementation of the stated action steps, and "timely" means that the due dates in the CAP were met or a reasonable explanation was provided for any delays. The Facility did not produce adequate documentation to the Monitoring Team to make this determination. There was not an adequate system for tracking the status of CAPs. Of the five CAPs being tracked by the Facility, for five (100%) the CAP Tracking Log indicated the status of the CAP and any action taken if a CAP had not been implemented. However, the data presented on the CAP Tracking log was not sufficient to determine if any specific actions had been taken as a result of CAP status review. Entries on the log typically were general	Noncompliance

#	Provision	Assessment of Status	Compliance
		statements such as "CAP no longer effective", "continue with current progress", and "will continue to monitor." The facility QA Director did maintain summary information/data (the CAP Tracking Log) regarding CAPs and their status that was updated within the month prior to the onsite review and did present this information to QAQI Council at least quarterly. Based on this review the Monitoring Team determined this Provision was not in compliance.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Data presented to the Monitoring Team with respect to assessing/measuring the effectiveness of the limited number of CAPs initiated by the Facility was insufficient to make this determination. The Facility QA Director reported that the Facility is still struggling with the CAP process and the requirements of the SA associated with the CAP process. For none of five CAPs (0%), documentation showed review of their effectiveness (i.e., outcomes), and for none of five CAPs (0%), documentation showed review of their timely completion. For example, CAP status was not always presented to the QA/QI Council. The QA/QI Council meeting attended by the Monitoring Team included a presentation of data for seven sections of the SA. The template used for each report included a section labeled "Corrective Actions." The Facility had a CAP directed at pre-treatment sedation practices (medical restraint) but the Section C (restraints) report to the QA/QI Council did not include any status report on that CAP. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	Noncompliance

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Self-assessment, updated: 09/23/2013 2. BSSLC Action Plans, updated: 09/19/2013 3. BSSLC Settlement Agreement Monitoring Entrance Presentations, dated Monday, October 7, 2013 4. Section F Presentation Book materials 5. Draft of updated DADS Policy 018.2: Most Integrated Setting, undated 6. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/12 7. DADS Policy Number: 017: Habilitation, Training, Education, and Skill Acquisition Programs, effective, 8/01/2013 8. BSSLC Policy F.1: Individual Support Plan (ISP) Process, implementation date 10/26/12 9. Standardized Assessment Templates, effective October 1, 2013 10. Available assessments on shared drive for Individual #140 11. Monthly Attendance by Discipline 5/1/2012-5/31/2013 12. ISP Attendance-ISP's only 5/1/2012-5/31/2013 13. Overall Facility Attendance Compliance ISP's only, 5/1/2012-5/31/2013 14. Individual Support Plans (ISPs), including ISP Preparation documents and related assessments, for Individuals #76, #106, #263, #288, #314, #445, #471, #483, #521, and #593 15. Thirty-Day ISPs for Individuals #240, #251 and #263 16. Sample of Monthly Reviews for Individuals #76, #106, #263, #288, #314, #445, #471, #483, #521, and #593 17. Alphabetical list of ISP dates, the date on which the ISP document was completed , the date ISP was filed and the date of the previous ISP, dated 9/11/2013 18. Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated September 25, 2013 19. Section F Monitoring Tool **People Interviewed:** 1. Pam Boehnemann, QIDP (Qualified Intellectual Disability Professional) Coordinator 2. Kim Littleton, Assistant Director of Programs (ADOP) 3. Susie Johnson, Director of Residential Programs 4. Melissa Moehlmann, Director of Education and Training 5. Lynsy Meier, Program Development Coordinator 6. Crystal Chavez, QIDP Educator 7. Daniel Dickson, Quality Assurance Director 8. Ric Savage, DADS Consultant **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #58 and #151 2. ISP Preparation Meetings for Individuals #330 and #337

	3. Section S Strategy Team meeting
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided its assessment of the results of the self-assessment and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Facility had in some instances coupled the self-assessment with its internal quality assurance processes to assess ongoing progress toward actual outcomes, in that it referenced the results of internal Section F Monitoring Tools. The Facility noted there remained concerns with inter-rater reliability, although this the trend was improving. Most of the activities engaged in to complete the Self-Assessment remained subjective, so it continued to be recommended the Facility identify some more discrete and objective indicators within the broader SA requirements that could be made more readily measurable. In order to complete a meaningful self-assessment, the Facility should further develop a set of outcome indicators that it believes would be likely to lead to substantial compliance based on its own experience and on the findings and recommendations in the Monitoring Team's report. This should include the identification of the data needed to measure these indicators. The QA Director indicated a revised monitoring tool for this section was currently being circulated that may address the ability of the Facility to accurately measure and substantiate its outcomes. The Facility also provided as part of its self-assessment Action Plans that reported on actions being taken or planned to achieve compliance. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. Sections of the Self-Assessment did not reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which would tie the Self-Assessment and Action Plans together. For example, for Provisions F1a through F2a3, the Facility's primary Action Step was to provide a good example of a complete ISP. The evidence that will be used to measure this was not defined, nor the process for measuring it. There was no clear indication what exactly the Facility expected to achieve as a result of implementing this Action Plan, nor how that would be measured. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved.
	Summary of Monitor's Assessment: BSSLC indicated it was not in compliance with any of the components for these provisions, and the Monitoring Team concurred. The assessment which follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. Positive findings included improvement in the implementation of the ISP process, particularly as observed in one of the on-site ISP annual planning

	meetings and the ISP Preparation meetings. The Facility had devoted considerable thought and resources to its integrated planning processes over the past six months and much of the progress appeared to be attributable to these efforts. Several key initiatives included the dedication of a DADS consultant to work with the QIDP department and the IDTs on ISP processes, the implementation of a Program Development Department for Skill Acquisition Plans (SAPs) and an energetic and creative Section S Strategy Team. The Monitoring Team was impressed with the progress. It appeared the Facility was poised to make tremendous strides in the upcoming months if it remains focused. The Monitoring Team commended these efforts, but did not find they had yet yielded substantial progress in the development and implementation of an integrated ISP for each individual that ensured individualized protections, services, supports, and treatments were provided, consistent with current, generally accepted professional standards of care. The Facility is encouraged to continue to build on its recent initiatives. Additional specific findings as to each provision are as follows: **Provision F1:** A revised ISP format and process had been introduced to the IDTs and considerable training and coaching was being provided, including dedicating a DADS consultant to work with QIDP staff. Some improvements in integrated planning were observed, particularly as observed in on-site ISP related meetings. Overall, documentation reviewed for the six month period indicated the Facility was still meeting with limited success specific to the requirements of this section of the SA. The IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. **Provision F2:** The Monitoring Team found there were some examples of improved integration observed in planning meetings and record reviews, and some additional initiatives to provide and document competency-based training. As indicated in the summary above, the Monitoring Team was particularly impressed with early results from the newly-implemented Program Development Department as it related to meaningful SAPs for individuals. Overall, however, the ISPs reviewed lacked many of the requirements specified in the SA for this Provision. ISPs still did not consistently specify 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 and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies. In documentation reviewed, SAPs were not yet sufficiently constructed or assessed for progress and ISP strategies still did not reflect encouragement of community participation in any meaningful or purposeful manner.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the		

#	Provision	Assessment of Status	Compliance
	Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	The Qualified Intellectual Disabilities Professional (QIDP) was the one person assigned to each individual to facilitate the work of each IDT. Beginning November 1, 2013, the Facility planned to use three Lead QIDPs as the facilitators for all ISP and ISP Preparation meetings. The assigned QIDP would co-facilitate and scribe, but the Lead QIDP would be responsible for developing the final ISP. The Facility had considered the potential workload issues related to this division of labor, which was designed to focus more QIDP effort on program implementation and monitoring. Its effect, however, would be for each Lead QIDP to be responsible for 96 ISPs, or an average of eight per month, in addition to ISP Preparation meetings. The Facility planned to monitor the outcomes related to timeliness and quality closely to ensure there were no unintended consequences. <u>Staffing of QIDP Department</u> The Facility reported that it had 15 QIDP positions, including three Lead QIDPs. The Facility was using the Q Construction Facilitation curriculum for training in this area and evaluating competence. Based on the list provided, only the three Lead QIDPs had been deemed fully competent in facilitation. There had been a substantial turnover in the department in the last six months, including some vacancies. At the time of the Monitoring visit, there were four new QIDPs, one new hire in orientation, two new hires with a start date of November 1 and two continuing vacancies. Staffing also included a QIDP Coordinator and a QIDP Educator. All individuals had an assigned QIDP. The QIDP/individual ratio appeared to be sufficient based on the workloads of staff as affected their abilities to manage and complete their tasks in an adequate and timely manner. The Facility was also again re-organizing certain aspects of its workflows and responsibilities to ensure QIDPs had sufficient time and opportunity to facilitate the team process and monitor implementation and progress. Preferences and Strengths Inventory (PSI) assessment processes had been delegated to the Active Treatment Coordinators beginning in August 2013 and another group of staff had been assigned write SAPs. Two additional positions were being made available to support the work of the QIDP. One position was to handle data entry; that person had been hired and was in New Employee Orientation during the monitoring visit. The other was an administrative position with duties that were still being defined, but may include data analysis, assistance with keeping minutes of meetings and possibly some additional monitoring. This position was in the posting process. Finally, the Facility was contemplating having the Residential Coordinators take over the completion of the Functional Skills Assessment (FSA), a responsibility currently delegated to the QIDPs. Overall, outcomes in terms of improvements in ISPs were not yet substantial. For example:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• For none of the ten plans reviewed or two meetings observed (0%) did the facilitation process result in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. • For none of the ten (0%) ISPs reviewed or two meetings observed (0%) did the facilitation process resulted in an adequate discussion of the most integrated setting. See Provision F1e. • For neither of the two ISP annual meetings observed (0%) did the facilitation process resulted in the adequate participation of the individual. • The assigned QIDP also remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found in its review of the sample that there was progress noted over previous visits, but the QIDPs did not yet consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provisions F2a6 and F2d. Conclusion: This provision was found to be not in compliance. The Monitoring Team was impressed with the effort and resources devoted to QIDP development and training and believed it held promise for future development.	
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	<u>Composition and Participation of IDT:</u> BSSLC Policy F.1: Individual Support Plan (ISP) Process and DADS Policy 004.1: Individual Support Plan Process, clearly identified requirements for team composition, attendance and participation and the processes for ensuring them. During the ISP Preparation meeting, the IDT was to identify the requisite composition of the team for the purposes of the annual planning meeting and record this in the Attendance-Assessment checklist. BSSLC's Self-Assessment indicated the Facility had analyzed data from two documents, an Attendance Tracking database from April through May 2013 and the ISP Process Monitoring database from June 2013 to July 2013, and found it showed overall attendance rates over 103 meetings stood at 87.7%. This included Individual participation at 70.9%, LAR participation at 59.2% and Direct Support Professional (DSP) participation at 82.2%. Additional documents were provided in response to the Monitoring Team's pre-visit document request in this area. These included documents entitled ISP Attendance-ISPs only, for 4/1/2013-5/31/2013, and ISP Attendance-ISPs only 5/1/2012-5/31/2013. No data were available for the month since May 2013 due to difficulties with the new database implemented in June 2013, so it was not possible to evaluate the Facility's attendance data for most of this monitoring period. It was reported by the QIDP Coordinator that the problems with the attendance database had been remedied the week before the monitoring visit and that accurate data would be available in the future. The Monitoring Team reviewed a sample of signature sheets for all ISPs held during September 2013 as an alternative measure. This review revealed the following rates of attendance for a sample of IDT members:	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>needs.</td><td>
<table>
<tr><th>Individual</th><th>LAR/ Family</th><th>QIDP</th><th>Nursing</th><th>Medical</th><th>Psychology/Behavior Analyst</th><th>Speech/ Language</th><th>DSP</th><th>Vocational/Day</th></tr>
<tr><td>59%</td><td>74%</td><td>93%</td><td>100%</td><td>93%</td><td>52%</td><td>37%</td><td>70%</td><td>44%</td></tr>
</table>

The rates of attendance noted for a month during the previous monitoring period, as shown below, indicated relative consistency for participation levels by the individual, family /LAR, QIDP, Psychology/Behavior Analyst, and Direct Support Professional. Participation by Vocational/Day program staff and Speech Therapy had dropped significantly since the previous review. Positively, participation by the Primary Care Provider (PCP) had dramatically improved, with a PCP in attendance at 25 of 27 meetings, and Nursing Services continued to be in attendance for all meetings.

<table>
<tr><th>Individual</th><th>LAR/ Family</th><th>QIDP</th><th>Nursing</th><th>Medical</th><th>Psychology/Behavior Analyst</th><th>Speech/ Language</th><th>DSP</th><th>Vocational</th></tr>
<tr><td>63%</td><td>83%</td><td>92%</td><td>100%</td><td>67%</td><td>46%</td><td>75%</td><td>79%</td><td>71%</td></tr>
</table>

<u>Extent of Individual participation in ISP:</u>
In addition to actual meeting participation by individuals, meaningful participation remained very limited, as reported in previous assessments by the Monitoring Team.

<u>Conclusion:</u> This provision was found to be not in compliance.</td><td></td></tr>
<tr><td>F1c</td><td>Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.</td><td><u>Extent to which assessments are conducted routinely:</u>
<u>Policy:</u>
DADS Policy #004.1 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP."

For annual ISP planning meetings, the expectations remained that the PSI would be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individuals' preferences and individual goals into their assessments and recommendations. The IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting, also held approximately 90 days prior to the ISP meeting. The policy requires in Section III.C that these assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting to permit the entire interdisciplinary team (IDT) to review them. The assessments were to be used by the QIDP to develop an ISP Guide no later than five days prior to the ISP annual meeting. For a new admission, Facility policy requires that the assessments be completed and</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		posted at least five working days prior to the initial ISP meeting. <u>Extent to which assessments are conducted routinely and in response to significant changes:</u> In response to a request for an ISP assessments tracking log, the Facility responded, "We started tracking assessment timelines in July 2013, with a new database we received from State Office. At this time, we have found some issues with the reports. We are currently in the process of fixing the problem(s) & I should be able to provide you copies at the onsite visit." When asked during the visit for updated materials, the Facility indicated there were none yet. In response to request for a description of how the Facility monitors to determine whether assessments are completed and filed, the Facility responded "No evidence." During the compliance visit, a consultant from DADS reported the Facility plans to implement a database developed at another SSLC. Assessments for the ISP were still not routinely completed on a timely basis, as evidenced by the Facility's own self-assessment and by other findings of the Monitoring Team, but there was improvement noted. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs had begun making use of this function, as five of ten (50%) recent ISPs clearly defined the assessments that were to be completed. Findings included: • In its Self-Assessment, the Facility reported its monitoring data for the period between April 1, 2013 and July 31, 2013 indicated comprehensive assessments were completed on a routine basis and when there has been a change in status 19.7% of the time. • In a sample of ten recent ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. • Overall for this sample, the rate of timeliness was 72%. It was not possible to ascertain assessments that might be missing altogether for five of the individuals, as the ISP Preparation meeting documentation did not clearly prescribe the required assessments; therefore the timeliness compliance rate provided above is based on whether the assessments available in each packet were completed within the required number (either five or ten) of working days before the ISP meeting was held. • As reported in Provision V4, the Monitoring Team also viewed the assessments available on the shared drive for Individual #140, who had an annual ISP meeting scheduled within the next ten working days. For 16 assessments that were required per the ISP Preparation meeting, 14 (88%) were current and posted by the due date. • Also as reported in Provision V4, audits of two active records found the following: o For Individual #532, eight of 11 assessments or updates listed on the Active Record Audit form and applicable to the individual (73%) were present and timely according to the assessment dates. o For Individual #533, who had been admitted since the last compliance visit, of 11 applicable assessments, four (36%) were completed at least five days prior to the initial ISP meeting, and six (55%) were completed within 30 days following admission.	

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		• As described in Provision F2d below, the Monitoring Team found assessments were not always being updated in response to significant changes, particularly as they related to protection from harm. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs/ assessments are conducted in response to significant changes:</u> BSSLC had taken several steps to improve the quality of its assessments such that they would more likely reliably identify the individual's strengths, preferences and needs. These included: • Effective October 1, 2013, the Facility had begun using statewide standardized assessment templates, with the exception of the Rights Assessment, Structural & Functional Assessment, and Pharmacy. These were intended to ensure all assessments would have a consistent foundation of information and analysis to be included. These templates were reviewed by the Monitoring Team. Each included specific sections, including the following: I. History II. Current Status (Diagnosis, Active Problem List, Risk Levels) III. Current Services (Medications, Treatments, Training, Supports) IV. Preferences, Strengths, Goals (from ISP Preparation meeting) V. Evaluation/Assessment Results VI. Additional Strengths, Contraindications to Stated Goals VII. Community Living/Services VIII. Summary IX. Recommendations The Monitoring Team found it was positive that DADS had established certain expectations. For the most part, however, the significant concerns the Monitoring Team had about the quality of assessments in the past had less to do with the format and more to do with the rigor of the assessment process. The Facility should guard against any tendency toward a fill-in-the-blanks approach to assessment as it moves forward with implementation of these new templates. • Five Active Treatment staff had been trained to complete the Preferences and Strengths Inventory (PSI) process, as described in DADS Policy 004.1: Individual Support Plan Process. This newly implemented process appeared to hold promise for a more thorough understanding of preferences and strengths. Progress was noted in certain discipline specific assessment processes and outcomes throughout this report. Examples included: • As reported in Provision M2, substantial compliance was maintained for Nursing Assessments. • As reported in Provision P1, which was found to be in substantial compliance, the Habilitation Assessment addressed the majority of components needed to fully assess an individual. Areas regarding comparative analysis, listing potential side effects related to medications, and investigating more ways to improve functional skills were slightly below the 90% threshold but showed marked improvement since the previous review.	

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		• As reported in Provision R2, assessments remained one of the stronger aspects of the Communication Section; however, they still lacked the comparative analysis piece that demonstrates improvement or decline of their health as well as communicative status. Also missing was information regarding the impact of medication on the individual's ability to communicate. • For 10 individuals in Sample O1 and O2 for whom the IDT identified changes needed to be made to the PNMP, ten ISPA meeting documentations (100%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For individuals for whom the PNMP was revised, there was supporting documentation that ten of ten individuals' revised PNMPs (100%) had been implemented. The Monitoring Team commends the Facility for these efforts, particularly as this has been an area of weakness overall. However, despite these strides, noncompliance continued to be found in the following provisions related to the quality of assessments: J6, K5, L1, M4, M5, O2, R2, S2, T1b1, T1b3, T1d. and U1. These findings, taken together, demonstrated assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. Examples included: • As reported in Provision U1, the Facility did not routinely use standardized or valid instruments, methodologies and/or processes to assess functional decisional capacity. • As reported in Provision T1e, assessments prepared for the Individual #52, whose CLDP was held shortly before the monitoring visit did not adequately address significant issues that could impact a safe transition to community living. • As reported in Provision R2, eight of 16 individuals' Speech assessments (50%) offered a comparative analysis of health and functional status from the previous year. It was noted the revised communication assessment included a specific section devoted to this topic in an effort to provide ease of review and will be utilized moving forward. • Also as reported in Provision R2, five of 16 individuals' Speech assessments (31%) included diagnoses and relevance of impact on communication. It was also noted that the reformatted Communication Assessment contained a section specific to identifying relevant diagnoses to allow for greater ease of review. • As reported in Provision J6, Comprehensive Psychiatric Evaluations (CPEs) reviewed they followed the recommended format. As a rule the sections on history of present illness, past history, family history, substance use, medical history, developmental information, social history, substance use, current medications, and mental status all exceeded required standards. The section on diagnostic formulation and diagnostic justification, however, needed continued attention and some improvement; those requirements were not always met. <u>Conclusion:</u> This provision was found to be not in compliance. Assessments were not completed routinely in a timely manner nor were they of adequate quality to reliably identify the individual's strengths, preferences and needs. The Facility's Self-Assessment confirmed this remained a significant	

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		area needing improvement.	
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.	Extent to which assessment results are used to develop ISPs: Current assessment practices at BSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for QIDPs to complete the ISP Guide five days before the ISP annual meeting that would have enabled IDT members to review before the meeting, nor were assessments completed with sufficient thoroughness. Even when the results of this flawed assessment process were used in the development of the ISP, the IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. For example: • As reported in Provision S1, nine of the ten individuals in the site visit sample (90%) had been provided a current intellectual assessment, but none of the SAPs for those nine individuals (0%) referenced or reflected the intellectual assessment findings. Eight of the individuals in the site visit sample (80%) had been provided with a standardized assessment of adaptive skills in the past year, but none of the SAPs for these individuals (0%) referenced or reflected the adaptive skill assessment findings. • As reported in Provision O3, none of 14 PNMPs (0%) were comprehensively reviewed by the individual's IDT in the annual ISP meeting. While the ISPs contained evidence of review, and specified the changes required to the PNMP, missing from the review was whether the PNMPs remained functional in mitigating risks associated with PNM and the evidence supporting these statements. For the two ISPs observed, the Monitoring Team found there was some improvement in the overall awareness of IDT members as to the content of the assessments and how these may contribute to the development of the ISP. Conclusion: This provision was found to be not in compliance.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581	Adequacy of process to develop each ISP in accordance with ADA and Olmstead decision This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the IDT needed to make a recommendation to the individual/guardian. For the ISPs reviewed the Monitoring Team found the required determination was still not being consistently provided. • Of the ten ISPs reviewed, for none (0%) did all of the assessments include the applicable statement/recommendation. Of the 93 total assessments reviewed, 35 (38%) included a determination of whether the individual could be served in a more integrated setting.	Noncompliance

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	(1999).	• Ten of ten ISPs (100%) included an independent recommendation from the professionals on the team to the individual and LAR that the individual could be served in a more integrated setting, but none (0%) made a referral. • Of the ten ISPs reviewed none (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting. For the most part, a template statement indicated that the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services might be needed in the community. • The Facility typically did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2, a relatively small proportion of individuals living at BSSLC had opportunities to tour community living options, and IDTs did not develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. In the section below that addresses Section T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. For example: • None of ten (0%) of the recently completed ISPs reviewed evidenced proficiency in identification and addressing of obstacles. • In none of the ten (0%) that identified LAR or individual choice as the barrier were there specific action plans developed to address these specific barriers other than providing annual CLOIP information and/or Provider Fair invitations. The Monitoring Team also continued to observe in the on-site ISP annual meetings that IDTs were not effectively addressing either the concerns of the LARs or offering information to LARs about the potential benefits of community living. There remained a clear discomfort on the part of the IDT members in this regard. For example, for Individual #151, the Lead QIDP explained to the LAR on several occasions that the team was "obligated" to have this discussion and "had to have" this discussion every year. The LAR indicated her fear was that if things didn't work out for the individual in the community, the only option would be to go to another home rather than returning to the Facility. Rather than addressing this openly expressed concern when the LAR brought it up, the QIDP Coordinator instructed the Lead QIDP to defer that until the end of the ISP annual planning meeting. This topic, once deferred, was never adequately responded to in the meeting. It is difficult to have such a conversation with a reluctant LAR or family member on an annual basis. This review of the recently completed ISPs and the observation of two ISP annual planning meetings during this monitoring visit indicated IDT members continued to need additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs over the course of the year. The ISP Preparation meeting also provided an opportunity to discuss the barriers and plans to address them, particularly in relation to ongoing interactions and discussions with reluctant LARs. The	

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		Monitoring Team observed two ISP Preparation meetings during the on-site visit and found there was discussion of community living options, but there was little focus on how to work with the LAR/family to prepare them for this discussion. As it relates to this provision, there was little overall progress demonstrated in the ability of the IDTs to identify 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. This may be attributed in part to a sequence that did not ask the team to actually determine the most integrated appropriate setting until after the individual's services and supports had been identified. This tended to perpetuate the tendency of the teams to focus primarily on the supports and services currently being provided at the Facility. While such an array may include many essential services and supports, it does not take into adequate consideration the varied needs that may be needed for successful transition and community living. The IDT must identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles to movement. The Monitoring Team was concerned that the new standardized assessment templates did not always clearly require the IDT members to provide an affirmative description of the individualized needs in a community living setting. If the IDT members have reached a general consensus that the individual could be served in a community setting, it is incumbent upon them under the SA and Olmstead to address what would be needed to facilitate that, regardless of whether a referral is made. If the team does not address these needs because a referral is not made, this results in little likelihood of a referral being made. Engaging the IDT, including the individual and family/LAR in a discussion of both obstacles and opportunities is an essential component of an ISP developed in accordance with the ADA and Olmstead. <u>Conclusion</u>: This provision was found to be not in compliance. To move in the direction of substantial compliance, the Facility should focus its efforts over the next six months on the following: Additional policy guidance and training should be provided to require, as a part of the ISP process, the IDT to not only make a determination regarding the most integrated setting appropriate to an individual's needs, but also describe what would be needed in that setting, including supports and potential obstacles in terms of their availability . This process should help to facilitate a discussion and inform the individual and LAR of the potential advantages of community living, such as having more privacy, or living in closer proximity to family. Having accomplished that, the determination of whether or not a referral will be made can be completed in which individual and/or LAR preference would take final precedence.	
F2	**Integrated ISPs -**		

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	Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed,	<u>Identification and Use of Individuals' Preferences and Strengths:</u> The ISP process had also been modified to an extent. In the current process, the IDT began with a discussion of preferences and strengths, and then addressed key goal areas before completing the risk assessment. In the review of ten ISPs, the Monitoring Team found that none (0%) had effectively incorporated individuals' preferences into related action plans. Preferences and strengths identified in the PSI were acknowledged at the beginning of the ISP Preparation meetings and ISPs, but were seldom reflected in assessments developed for the annual ISP and/or integrated throughout the narrative and/or discussion of the ISP. The Monitoring Team noted a requirement in the new standardized assessment templates to address preferences and strengths. The Monitoring Team did observe some Action Plans related to preferences. Action Plans to address strengths were not observed, nor did Action Plans developed for various needs also incorporate approaches to integrate strengths in the methodologies. Overall, as reported in Provision S1 the percentage of SAPs reflecting integration of preferences and strengths remained low, at 20%. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed:</u> In none of ten ISPs (0%) were barriers adequately identified and addressed. Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs.	Noncompliance

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	and encourages community participation;	As reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of ten (0%) recent ISPs reviewed for which a referral had not been made evidenced proficiency in this regard. Extent to which ISP encourages community participation: Seven of the ten ISPs (70%) reviewed included specific skill acquisition action plans for implementation in the community, in which the objective provided a specific purpose and methodology, was couched in measurable terms, and defined a data collection and analysis process. Most of these Action Plans were still general in nature and did not appear to be individualized; six of the seven called for individuals to engage in exchange of money for purchases in the community, and none were designed to occur more than once per week. Only one ISP included Action Plans that were clearly individualized to address specific preferences and promote actual community participation. As recommended in Provision T1b2, the Facility's IDTs should develop an individualized community participation strategy for each individual that takes in to account their specific learning needs, preferences, and strengths. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community; and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. The ISP Preparation Meeting offered an opportunity to focus the attention of the IDTs on ensuring that each of these requirements is adequately represented in each individual's ISP. The Monitoring Team attended two ISP Preparation meetings and found there were indications the meeting was being appropriately used in this manner to a certain extent. There were tentative Action Plans discussed regarding preferences in both instances, although strengths were less well addressed. There were also discussions about supports for community integration, but additional emphasis on developing a comprehensive and functional plan for community integration and awareness will be required. Conclusion: This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or	Extent to which ISP 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: As described in Provision F2a4 and further in Section S, ISP programs were still generally not individualized to the individual's needs, nor did they contain the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions. BSSLC failed to conduct individual task analyses. As a result, SAPs were not tailored to the unique learning needs, current skills, or physical condition of each person.	Noncompliance

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	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;	For the ten ISPs reviewed, it appeared the ISPs being developed still did not included a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. The IDTs did not consistently develop such a comprehensive complement of individualized goals and objectives that were relevant to and likely to lead toward attainment of outcomes related to each preference, meet identified needs, and overcome barriers to living in the most integrated setting. Examples included: • As reported in Provision R3, three of 16 ISPs reviewed (19%) included how communication interventions were to be integrated into the individual's daily routine. • Also as reported in Provision R3, eleven of 16 ISPs reviewed (69%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPs were not consistently developed to address identified concerns with communication. • As reported in Provision S1, skill acquisition plans (SAPs) were chosen in an individualized manner only 10% of the time. Significant enhancements to the Facility's processes in these areas were underway, however. These included the creation of a Program Development Department and a Section S Strategy Team to guide the development of new skill acquisition training procedures and track the outcomes of the new efforts. The Section S Strategy team was made up of the Director of Education and Training, the Director of Behavioral Services, the Director of Residential Services, the QIDP Coordinator, and the Program Development Coordinator. The Section S Strategy Team was supported by a DADS consultant. As reported in Provision S1, this team had begun the process of revising SAP practices, training staff, and establishing metrics and monitoring procedures. In a review of Policy S.1 – Skill Acquisition Program Development, it was noted that the policy involved an outline of assessment practices, the content of skill acquisition programs, the manner in which staff were to be trained, and how skill acquisition and SAP benefit would be monitored. This represented an improvement in guiding the development of skill acquisition programming. The early evidence of the results of these enhancements, as represented in the on-site ISP annual meetings observed, was positive. During the meetings observed, members of the Program Development Department presented proposed goals that were tied to preferences, strengths and needs, and furthermore had been trialed with the individuals in the time between the ISP Preparation Meeting and the ISP annual meeting. <u>Adequacy of processes for identification of and plans to overcome barriers</u>: In the section below that addresses Provision T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, barriers to living in the most integrated setting did not always lead to goals, objectives, or	

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		service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. As reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of ten (0%) recent ISPs reviewed evidenced proficiency in this regard. Also see Provision F1e above. The Monitoring Team again noted the ISP Preparation Meeting offered an opportunity to focus the attention of the IDTs on ensuring these requirements would be adequately represented in each individual's ISP. See Provision F2a1. Conclusion: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions: This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's needs and supporting his/her aspirations and preferences. In such an approach, one would expect to see, for example, training in independent living skills to also have components that might include communication skills development, strategies for use of the skills in community settings, incorporation of positive behavior support techniques, risk action plans, etc. A program to improve dining skills might include techniques to encourage eating at a reasonable pace for both social and risk prevention purposes; use of a graphic menu to assist the individual to identify preferences, learn the names of foods and make choices; incorporation of reinforcement for safe dining behaviors and/or replacement behaviors; and might describe both formal and informal opportunities for community dining. Overall, adequate integration should be demonstrated through: o Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, integrated health care plans, etc.,) in a measurable way into the ISPs, through, for example, measurable objectives; o Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans; o Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) o Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary The Monitoring Team did find evidence that integration was improving. For example, As reported in Provision M5, three of five recently Integrated Risk Rating Forms and Integrated Health Care Plan Forms (60%) IHCPs were sufficiently integrated among all appropriate disciplines. The Monitoring Team also observed two ISPs and two ISP preparation meetings during the on-site visit. There was some progress noted in these meeting as well, particularly as it related to the development of SAPs.	Noncompliance

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		The Monitoring Team found that, although teams were making progress in their efforts to identify and incorporate individuals' preferences and work in a more integrated manner, none of the ten (0%) plans reviewed for this section integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. Other examples that demonstrated that ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual included: • As reported in Provision O2, for three of five individuals (60%) were all recommendations by the PNMT addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. • As reported in Provision P2, ten of 20 ISPs or ISPAs (50%) integrated the OT/PT interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. ISPs simply stated that the individual had a PNMP and the IDT approved it. • As reported in Provision R3, three of 16 ISPs reviewed (19%) included how communication interventions were to be integrated into the individual's daily routine. Eleven of 16 ISPs reviewed (69%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not consistently developed to address identified concerns with communication. • As reported in Provision J8, the Facility clarified that improvement in the area of integrated care at the level of the ISP had been a major focus for psychiatry, and the vehicle for improving psychiatric information improvement in that area was the psychiatric contribution to the IRRF reviews. Improvements were noted but adequate IRRFs were present for only four of 10 (40%) of individuals in Sample J1. • As reported in Provision M5, three of five recently developed Integrated Risk Rating Forms and Integrated Health Care Plan Forms (60%) IHCPs were sufficiently integrated among all appropriate disciplines. <u>Conclusion</u>: This provision was found to be not in compliance. Overall, additional training was still needed to prepare teams to think creatively about the needs and preferences of individuals and how to address them on a person-by-person basis in a way that involves collaborative planning and recognition of the possible contributions of several disciplines to an area of need and/or preference.	
	4. Identifies the methods for implementation, time frames for completion, and the staff	<u>Adequacy of methods for implementation:</u> The Facility did not yet consistently identify adequate methods for implementation. Examples included: • Findings in Provision S1 indicated that during the current site visit, despite some improvement, the SAPs lacked many of the essential components of a skill acquisition program. One possible reason for this circumstance involved the lack of individualization in the SAPs. Without individualization, essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions	Noncompliance

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	responsible;	cannot be adequately presented. • As reported in Provision P2, for 0 of six individuals (0%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. • As reported in Provision R3, for two of five individuals (40%), staff instructions/skill acquisition plans related to the AAC system were available. <u>Adequacy of identification of time frames in action plans:</u> For none of the ten ISPs reviewed (0%) did action plans include adequate timeframes for completion. This assessment was based on a review that indicated timeframes were not individualized according to need and activity, but rather consisted for the most part of a standard (i.e. one year) completion date across the board. There were exceptions, but these were very limited. For the two new ISP annual planning meetings observed, however, the Monitoring Team noted timeframes were more frequently being developed that were based on individualized assessment of needs. This was a positive development. <u>Adequacy of identification of persons responsible in action plans:</u> The ISPs typically indicated by position who would be responsible for program implementation, documentation and data review. This did not yet appear to be sufficient to achieve the outcomes of ensuring program implementation was accomplished as required, however, as evidenced by the finding described above that methods of implementation were not adequately constructed by those identified as responsible for designing the specifics of the action plans. This was further evidenced by findings in in Provision F2f which indicated that ISPs, including the completed Action Plans, were not consistently being put into place on a timely manner by those identified as responsible for ensuring plan development. <u>Conclusion</u>: This provision was found to be not in compliance.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional	<u>Adequacy of interventions, strategies and supports that are practical and functional at the Facility and in community settings:</u> To establish compliance in this provision, IDTs must develop individualized action plans that effectively address the individual's assessed needs for services and supports and to promote increased independent functioning both at the Facility and in the community, as well as design interventions, strategies and supports that can be practically implemented both at the Facility and in community settings. None of the ten plans (0%) reviewed effectively addressed the individual's full array of needs for services and supports in a manner that was practical and functional across settings. Overall, as reported in Provision S3a, the Facility experienced difficulty in developing SAPs that were functional for the individual. There was little evidence to support that assessments were used in the development of SAPs. It was therefore not unexpected to find that only one of the 10 SAPs (10%)	Noncompliance

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	at the Facility and in community settings; and	addressed needs specifically identified in the assessments. Despite the weaknesses in the use of assessments, however, the sample did reflect somewhat better performance in targeting skills likely to be useful to the individual, with four of the 10 SAPs (40%) rated as successful. Conclusion: This provision was found to be not in compliance.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress: There is an extensive discussion in Provision S1 related to issues negatively impacting the identification of data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress. These issues included: • In the majority of skill acquisition programs reviewed at BSSLC, the teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill. • The Facility achieved substantial progress in ensuring a valid and reliable method of measuring and documenting the performance of the person being taught. The percentage of SAPs that described adequate documentation procedures increased from 57 percent to 80% since the previous monitoring visit. • Despite the improvement in the documentation procedures, the actual recording of training data remained poor. There were also indications that the Facility was not effectively monitoring data and individual progress. Due to the factors relating to SAP documentation, it was not evident that the Facility was able to identify and implement an effective strategy to document skill acquisition. As a result, it was generally not possible for the IDT to determine when an individual was benefiting from teaching and developing functional skills. Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review: For ten of the ten ISPs reviewed (100%), the Action Plans defined the person(s) responsible for data collection. Similarly, for ten of the ten ISPs reviewed (100%), the Action Plans also clearly defined the person(s) responsible for data review. This did not appear to be sufficient to achieve the outcomes of ensuring program review was accomplished as required, however, as evidenced by the findings described in Provision F2d below. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation	Adequacy of coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP: This provision requires that disciplines work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The Facility continued to implement initiatives toward coordination among staff, including the development and monitoring of	Noncompliance

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	within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	the IRRF, the Integrated Health Care Plans (IHCPs) and a variety of routinely scheduled cross-discipline meetings. For example, as reported in Provision R2, the SLPs and psychologists continued to improve collaboration on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. Behavior Services and Speech continued to use a PBSP/Communication Assessment Checklist that was designed to improve consistency between the two documents and assist in identifying areas in which there is cross over between the two disciplines. The Monitoring Team commends the Facility for these initiatives to promote staff coordination in the development and monitoring of supports and services. Overall, however, coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP continued to be lacking, as described throughout this Section F and in other sections of this report. For example, as reported in Provision T1b2, the Facility should have, but did not create comprehensive coordinated plans for community living education and awareness for individuals. Such plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	<u>Extent to which ISP is accessible and comprehensible to staff:</u> The ISP appeared to be accessible to staff. • A copy of the ISP was filed in each individual's All About Me book (Individual Notebook). • There was some progress noted, in terms of outcomes, that staff comprehended how to implement the ISP. For example, as reported in Provision O4, staff did a much better job engaging in safe mealtime practices. • As reported in Provision K11, in an attempt to ensure that all BAIPs are easily read and interpreted by staff, BSSLC required that the staff instructions section of each BAIP be written at 8th grade level or below. To ensure this requirement was met, BAIPs were not granted final approval by the PBSC until software for determining readability had shown this goal to be achieved. A review of tracking data revealed that average readability level for all 53 BAIPs reviewed by the PBSC since the last site visit was grade 7.6 with a range of grade 5.9 to grade 8.9. Overall, however, observations and review of program data indicated that the ISP did not appear to be comprehensible to the staff responsible for implementing it, as there were many instances in which staff could not describe supports contained in the ISP or did not implement them as called for in the ISP. Examples included:	Noncompliance

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		• As reported in Provision O4, per observations conducted by the Monitoring Team, 17 of 23 individuals' (73%) dining plans were implemented as written. Seven of 20 individuals' positioning plans (35%) were implemented as written • As reported in Provision R3, none of five observations (0%) found AAC devices present in each observed setting and readily available to the individual. AAC systems for zero of five individuals (0%) were noted to be in use in each observed setting. • Also as reported in Provision R3, Two of eight staff interviewed (25%) were knowledgeable of the individuals in Samples R.4 and R.5 and their communication related programs. • As reported in Provision S1, based upon the observations conducted during the current site visit, it was evident that overall functional engagement had decreased slightly from 34% to 32% of individuals. Observations reflected that four of the 12 observed locations (33%) reflected functional engagement for at least 50% of the individuals present during the observation. <u>Conclusion</u>: This provision was found to be not in 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	<u>Monthly review of progress</u>: The Facility had returned to requiring the QIDP to make an overall monthly review and evaluation of progress rather than a quarterly review. The ISP Preparation meeting also provided an additional important vehicle to ensure the IDT was alerted to a lack of progress and/or significant changes, either of which would call for needed modifications to be assessed and implemented. This preparatory activity should serve as a complement to the monthly review process and ongoing IDT discussions that should be occurring. The Monitoring Team observed there continued to be progress in the actual timely completion of the monthly reviews. • For nine of ten ISPs (90%) completed prior to the monitoring visit, there was evidence the QIDP had made a timely monthly review over the past six months. • As reported in Provision R3, for five of five individuals (100%) progress notes occurred at a minimum monthly. There was also some progress noted in the substance of the recent monthly notes; however, the IDTs did not consistently ensure assessment of progress on a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. Most of the monthly reviews provided little actual progress evaluation or led to any program modification. The Monitoring Team found additional evidence that the Facility did not ensure the responsible interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions and/or take action as a result of a lack of progress. • As reported in Provision O6, none of the 17 individuals' records in Samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring	Noncompliance

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	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.	forms. QIDP monthly reviews only stated that services were provided and provided no information regarding status of the individual or if the individual had any issues related to PNM or if the plan had been revised over the past month. • As documented in Provision P2, for 0 of 20 individuals (0%) with PNMPs, there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. This provision of the SA also requires the IDT to meet if a significant change in the individual's status has occurred to determine if the ISP needs to be modified, and make the modification as appropriate. The Monitoring Team found there were a number of examples in which the IDT should have taken assertive action to address the needs for services, supports and protections but did not. BSSLC IDTs needed to be attentive to emerging needs and take assertive action sooner rather than later. Examples included: • As documented in the previous monitoring report, Individual #286 had experienced a number of falls which had not been adequately evaluated or addressed by the IDT. During the April 2013 monitoring visit, another fall had sustained significant injuries requiring hospitalization. This series of events was of great concern to the Monitoring Team as it indicated the IDT had not recognized nor engaged each other in discussing falls that were occurring on an ongoing basis; had not acted in a timely manner to assess the falls assertively; and did not set an appropriate expectation regarding the individual's protection going forward. The Monitoring Team reviewed the individual's progress since the last visit and was disturbed to find the IDT still had not acted assertively to develop and put into place enhanced supports to protect the individual from continued harm. The individual continued to have multiple falls and his injury from April had not yet healed. • Findings in Provision L1 indicated this was not an isolated approach to addressing fractures. Those findings included the following: o In zero out of five cases (0%), there was documentation on the annual medical summary, quarterly physician reviews, PT/OT assessments, and ISPs, indicating that prescribed supports and services to help prevent falls and fractures, were routinely assessed for efficacy. There were no examples of the medical provider's conducting quarterly medical assessments. PT/OT assessments, and annual medical summaries reviewed did not specifically document all necessary supports and services necessary for prevention of falls and fractures. o The Facility did not provide committee meeting minutes, or other relevant documentation indicating that it conducts regular meetings to address fractures, and mechanisms to reduce fractures, as part of a system review at the Facility. • Individual #490 returned to the Facility approximately in August 2013, approximately 30 days after transitioning to community living. The individual, who had a history of mouthing which had been identified but not otherwise addressed in the pre-placement Behavioral Assessment and Intervention Plan (BAIP), had swallowed a battery and been hospitalized for its removal	

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		just prior to returning to the Facility. Upon return, the individual also was observed by staff to ingest a paper clip. Despite these events, the IDT did not act assertively to put adequate protection from harm provisions in place. The BAIP, dated April 2013, had not been updated to address this significant behavioral and protection from harm need. The PNMP, dated September 4, 2013, did not reference pica behavior. The most recent Integrated Risk Rating Form (IRRF) was from January 2013 and had not been updated since the individual returned from the community. <u>Conclusion</u>: This provision was found to be not in compliance.	
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	<u>Extent and adequacy of competency-based training for staff responsible for development of ISPs:</u> As noted in the Summary of Monitor's Assessment, the Facility was implementing a revised ISP process, with an expanded focus on training and mentoring for all IDTs, rather than just four focus teams. Training was being provided by a DADS consultant and the QIDP Coordinator on an ongoing basis, both in classroom settings and through hands-on mentoring in ISP related meetings. There was evidence, as supported by findings throughout this Section F, that positive changes to the ISP process were resulting. The Monitoring Team commends this concerted effort and encourages DADS to continue to provide support to the Facility in this area. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> The Facility continued to work towards other competency-based training for staff responsible for implementation of ISPs. Examples included: • The Facility had recently implemented a Corrective Action Plan (CAP) that addressed the QIDP monitoring of the competency-based implementation of ISP. In this process, the Facility had developed an observation form to judge competency to be used by the QIDPs, who had also been trained on the tool and protocol. This process had been implemented August 1, 2013. • As reported in Provision O5, staff responsible for training other staff did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. • Provision M4 continued to show a robust competency based educational program that tracked all required training and ensured the training was completed. There was evidence through interviews with nursing administration and management staff, and individuals' records reviewed, that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficient to meet individuals' health care needs. This Provision continued to be in substantial compliance. Overall, however, the Monitoring Team found staff were not yet adequately provided with competency-based training. For example; • As reported in Provision O5, a formal process did not exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical	Noncompliance

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	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.	or nutritional management problems received individual specific training prior to working with the individuals. • There was a lack of active treatment and engagement observed and a lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record. The Monitoring Team conducted observations in a variety of settings across the BSSLC campus with the following findings: o As reported in Provision S2, based upon the observations conducted during the current site visit, it was evident that overall functional engagement had decreased slightly from 34% to 32% of individuals. Observations reflected that four of the 12 observed locations (33%) reflected functional engagement for at least 50% of the individuals present during the observation. o As reported in Provision O4, implementation of positioning plans continued to be extremely concerning as the plans were implemented minimally and the issues noted may have a significant impact as it relates to the risk of skin breakdown as well as aspiration and pneumonia. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent	<u>Extent to which ISPs are developed within 30 days of admission:</u> The Facility reported 11 admissions during this six month period. For each (100%), it was reported the ISP was developed within 30 days of admission. The Monitoring Team reviewed the ISP and assessments for a sample of three of these. The ISP annual planning meeting was held for each of these within 30 days of admission. Assessments were not consistently completed on a timely basis for this sample, however, calling into question whether the IDT had all the information it needed to develop an appropriate and comprehensive plan. Data reported in Provision V4 and detailed in Provision F1c above for a fourth newly admitted individual (#533) indicated similar concerns as to availability of assessments when the ISP was developed. <u>Extent to which ISPs are revised annually and as needed:</u> In assessing this Provision the Monitoring Team relied primarily on a list provided by the Facility that included each individual in residence, the date of their most recent ISP meeting, the date of the previous ISP meeting, and the date the most recent ISP was put into effect. This list was dated 9/11/2013. From this list the Monitoring Team was able to determine that only five of 288 (2%) were listed as having been held more than 365 days past the date of the previous ISP. The same list was reviewed to evaluate whether the Facility had put the ISPs into effect within 30 days of preparation. The Monitoring Team evaluated this annual list as a means of assessing timeliness of implementation. While progress was noted as described below, there were still significant deficiencies in the Facility's current practices: • 40 of 288 (14%) ISPs were not implemented within 30 days of the ISP meeting during the past	Noncompliance

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	grants a written extension.	year. • The Monitoring Team had observed as a positive sign in its previous report that the rate of delinquent ISPs seemed to be decreasing. This trend did not appear to be continuing. Of the 40 ISPs that were delayed in implementation, 22 were for plans that should have been implemented within the past six months. Nine of these were implemented at least sixty days beyond the ISP date. • The Monitoring Team did note continued progress in the increasing number of ISPs that were being implemented within two weeks of the ISP annual meeting date. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The Monitoring Team reviewed the Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated September 25, 2013 and interviewed the Quality Assurance Director regarding the status of quality assurance processes for identification and remediation of problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section. Findings included: • The Facility continued to implement the Section F Monitoring. Each month the three lead QIDPs, the QIDP Educator and the QIDP Coordinator completed a tool for an ISP completed 60 days prior. A QA Auditor then completed an inter-rater audit for two of these, per the interview with the QA Director. It was reported that there remained discrepancy in inter-rater reliability as reported during the last monitoring visit, but the trend was improving. Current data from this process indicated the Facility was approximately 45% compliant with the provisions of this section in the most recent month (July 2013) for which data were available. • A draft of a revised monitoring tool for this section was currently being circulated for comment that was reported to be more in line with the revised ISP process. It would include review of documents related to both the ISP and the ISP Preparation meeting. • The Facility continued to implement a CAP related to competency-based training, as described in Provision F2e above. <u>Conclusion:</u> This provision was found to be not in compliance. The Facility was continuing to develop its quality assurance processes.	Noncompliance

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment 9/23/13 2. BSSLC Action Plans 9/19/13 3. Presentation Book for Section G 4. DADS Policy 009.2 Medical Care 5/15/13 5. BSSLC Policy H.1 Minimum Common elements of Clinical Care Ensuring Integration of Clinical Care 11/30/12 6. BSSLC Procedural Guidelines for On-Campus and Off-Campus Consultations 2/28/13 7. Provision Action Information for Section G 8. Minutes of Morning Medical Debriefings of 9/9/13, 9/10/13, 9/11/13, 9/12/13, 10/7/13, 10/8/13, 10/9/13, 10/10/13, and 10/11/13 9. ISPAs and other information documenting interdisciplinary team (IDT) follow up to the Morning Medical Debriefings of 10/7/13, 10/8/13, 10/9/13, 10/10/13, and 10/11/13 10. Minutes of the Health Compliance Team meetings of 5/14/13, 5/22/13, 7/26/13, and 8/21/13 11. BSSLC Procedure Guidelines for On-Campus and Off-Campus Consultations 2/8/13 12. Response to a document request for "Forms used by any discipline to document review of and response to recommendations from non-Facility clinicians" 13. Sample of medical consultation reports for Individuals #27, #96, #111, #141 (x2), #259, #281, #288, #323, #325, #408, #473, #532, and #533, and Modified Barium Swallow Studies (MBSS) for Individuals #159, #206, #255, #350, and #448 **People Interviewed:** 1. Mary Ann Brett, MD, Director of Medical Services, and Penny Foerster, RN **Meeting Attended/Observations:** 1. Morning Medical Debriefings 10/8/13 and 10/9/13 2. Annual ISP planning meeting for Individual #58 3. ISP Preparation meeting for Individual #330 4. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section G, in conducting its self-assessment, the Facility reviewed and presented information limited to attendance at ISPs (presumably the annual ISP planning meetings), and noted that the input of data on attendance has not been reliably correct. ▪ Did not use monitoring/auditing tools. Although some requirements of this section might not be amenable to the use of monitoring and auditing tools, some useful information might be gathered

	from internal and external medical audits, monitoring of the consultation process, or audits of integration of services and supports in ISPs. The Facility noted there is a lack of a uniform monitoring system for follow up from the morning medical meeting. ▪ Used other relevant data sources and/or key indicators/outcome measures limited to the attendance data noted above. ▪ The data provided did not cover the range of requirements of the Section. The Facility should review the findings in the report and identify measures that would be relevant to assessment of status. ▪ The Facility rated itself as being in compliance with neither provision of Section G. This was consistent with the Monitoring Team's findings for Provision G1. The Monitoring Team did find substantial compliance with Provision G2. In the self-assessment for Provision G2, the Facility stated the lack of compliance was due to a need refine the audit process for tracking non-SSLC clinician's consults and to produce several months of data on referral to teams and implementation of recommendations. The Monitoring Team agrees that this is needed; the Facility was able to provide three months of data by the time of the compliance visit, and the Monitoring Team believes this system has potential to increase referrals to IDTs, to document implementation of recommendations is occurring, and to catch any regression early. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Three of four actions were reported as Complete and one as In Process. ▪ The Facility data identified in the Self-Assessment areas of need/improvement. The Action Plan did not specifically address those areas. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Although the actions to be taken were appropriate and could lead toward compliance, two problems existed. First, they left many areas required for integration of clinical services not addressed, focusing only on attendance at meetings but not on collaborative case formulation, involvement of multiple disciplines to address a specific area of need of an individual (such as a medical condition like diabetes or reduction of problematic behavior with needs for psychiatric, behavioral, and communication therapy involvement), and collaborative development of facility-wide systems to assess health status and address means to improve. Second, the plans require a much greater level of detail. For example, an action was completed to establish a Health Compliance Team to review Facility data and evaluate facility-wide databases; this team had met three times. No actions were identified for what the team should do either in terms of what would be evaluated or what the team would do with the information to improve supports and services or achieve compliance with Section G requirements (or those of any other Section).
	Summary of Monitor's Assessment: Continuing improvement in collaboration and integrated planning were evident. The Morning Debriefing provided an excellent venue for integrated discussion and identification of issues needing collaborative planning; participation was clearly integrated, and disciplines used this as an

	opportunity to provide education and information to other disciplines. There were numerous interdisciplinary committees and workgroups. There were examples of excellent integrated planning, and other examples in which this needed improvement. Integrated clinical planning and services continue to evolve; to achieve substantial compliance, the Facility needs to continue to help staff identify inconsistencies among assessments and related services, to improve the consideration of how risks in one area of functioning and health may affect other areas and the services needed, and ensure assessments are timely so the information from one discipline can be considered by others when planning supports and services. Documentation of review and acceptance of recommendations was routinely found on consultation forms and in integrated progress notes (IPNs), and the minutes of Clinical Morning Report meetings documented examples of follow up with interdisciplinary teams (IDTs), this provision is found to be in substantial compliance. Therefore, this provision was found to be in substantial compliance. Although there were examples of referral to interdisciplinary teams (primarily through the Morning Medical Debriefing) and discussion or documentation of follow-up action, referral through the consultation process itself was infrequent. The Facility had begun a monthly process of audit of consults and provided information on consults audited. Information was gathered by auditing a sample of consultations, using a standard audit form. The new audit process may affect referral to IDTs and documentation of follow-up, but it is too new to determine whether this occurs.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility reported not yet being in compliance with this provision. Although the Provision Action Information document did not report any actions taken since the last compliance visit. The Self-assessment noted "a significant improvement in attendance at ISPs by many disciplines and this represents substantial progress." Through review of documents, interview with the Medical Director, and review of information regarding several sections of this report, Monitoring Team also noted continuing progress. This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's clinical. Overall, adequate integration of clinical services should be demonstrated through: • Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, and integrated health care plans) to address the same issue. For example, training in independent living skills might have components that include communication skills development, strategies for	Noncompliance

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		use of the skills in community settings, and incorporation of positive behavior support techniques. Treatment of a health condition might involve medical services, nutrition services, exercise and leisure activities, and behavioral services to increase compliance with health care, all aimed at the same goal of improving the diagnosed condition. • Information from assessments of various disciplines is integrated into and consistent across services or interventions so plans for treatments, supports, and intervention are consistent with that information. For example, prompts provided during skill acquisition training should take into account communication skills identified in communication assessments, sensory and physical movement issues identified in OT/PT assessments, and information from psychology assessments about intellectual function and adaptive behavior. <u>Policy</u> BSSLC Policy H.1 Minimum Common elements of Clinical Care: Ensuring Integration of Clinical Care continued to be the guiding policy relevant to this provision. This had not been revised since the last compliance visit. <u>Morning Medical Debriefings</u> BSSLC continued the daily Medical Morning Debriefing meetings. The Morning Medical Debriefing is chaired by the medical director and conducted five days per week. It is an integrated, multidisciplinary meeting that consists of medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, quality assurance, dental, and pharmacy services. There was a standard agenda and format for the meeting. This included the following standard topics: • On-Call Physician Report • On-Call Psychiatrist Report • On-Call Psychologist Report • Individuals in a Hospital • Individuals Sent to ER • Review Follow Up Items • Pre ISP & ISP Meetings Today • Missed Appointments • Additional Notes The Monitoring Team attended Morning Medical Debriefing meetings of 10/8/13 and 10/9/13 and reviewed minutes of the meetings of 9/9/13, 9/10/13, 9/11/13, 9/12/13, 9/13/13, 10/7/13, 10/8/13, 10/9/13, 10/10/13, and 10/11/13. Observations were consistent with those of the last two compliance visits. The discussion was balanced and	

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		integrated across the clinical disciplines and helped contribute to continuity of interdisciplinary care, as described in the following comments. The meetings enabled all members to gain greater insight into the clinical management of individuals reviewed during the meeting. • Discussion during the meeting about an individual who had PNMT issues and how they related to medical and behavioral concerns was a good example of integrated care. • For an individual returning from the hospital, there was discussion of issues requiring IDT review, and notice that the IDT had scheduled a meeting for later in the day. • There was discussion of an issue raised at the annual ISP planning meeting for Individual #58 the day before, focusing on a plan for the individual to be taken home for Thanksgiving, the IDT's hypothesis that he had increased problematic behaviors when he did not go home for the holiday last year, and, briefly, the supports that would be needed from various disciplines to make that possible. • There was extensive discussion arising from the Incident Management Review Team discussion the day before about Individual #44, who had an increase in falls. Discussion of issues that might be contributing included increased anxiety, discrepancy in leg length with contracture, and type of shoes worn. At least three disciplines were reported to be addressing these issues. Psychiatry had a proposal for a medication change; this was to be reviewed the next day by the Human Rights Committee. Physical Therapy had assessed different shoes and was waiting for a fitting by an orthotic shoe vendor. Although there was no PBSP, the psychologist discussed the use of headphones to reduce noise and help her remain calm, and described how this had worked for another individual. The pharmacist discussed the options for psychotropic medication choices and provided explanation of long-acting versus short-acting medications and when one is preferable to the other. A physician noted there had been discussion of the possible influence of chronic pain but that trials of several medications had not resulted in behavior change. Another physician asked about a gait belt (and was informed the individual had one but does walk on her own); this physician also stated a plan to discuss the medications with the Psychiatry Director. The Residential Director discussed a possible move to a different unit in which the population is less active, which might reduce the individual's anxiety; the psychologist suggested some falls may occur when the individual is trying to move away from active and noisy people, and stated she would follow up on the headphones. As evident from this report, the discussion was wide-ranging and comprehensive across several disciplines. Minutes reviewed by the Monitoring Team indicated that all topics on the standard	

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		agenda were reviewed at every meeting. Most topics had columns for needed information, such as name of individual, action plans, whether follow up is needed, and date of completion or closure. Documentation was provided if the topic was not applicable to a specific meeting, such as if there were no individuals in the hospital. The Additional Notes section of the agenda provided an opportunity to bring up both individual and systemic issues that were not noted earlier in the agenda, as well as to provide information and notices. Information found in the minutes noted examples of integrated planning, referral for IDT review, and follow up on both individual and systemic actions. Examples include: • In some minutes, documentation reported change of status, IDT review, and actions to be taken. An example of this documentation was for Individual #332 on 9/9/13. • Minutes also documented discussion and action on systemic issues. The minutes of 9/11/13 reported a question about whether there was a "pain trigger class in orientation." The group agreed this should be done, and a note in the Follow Up/Closure column stated the Residential Director reported later in the day that this is being included in orientation. • Minutes of the meeting of 9/11/13 reported on the issue of falls for Individual #51. The action plan column described a strict schedule of increasing time the individual will spend in his walker, and that this was going well. It gave a Follow Up/Closure date of 9/11/13. • Minutes of the meeting of 10/8/13 discussed, in Additional Notes, observations by staff that Individual #19 was pocketing food. The minutes reflected an integrated discussion revolving around the individual's progressing dementia, the plan for an emergency swallow study, recent episodes of dehydration, and the need for an IDT meeting. The Facility provided a Habilitation Therapies Consultation Report of 10/17/13 which described assessment including observation of enteral feeding through a G-tube received 10/14/13 and an evaluation and recommendations for return to oral intake, and provided recommendations; this verified follow up from the discussion of the Debriefing meeting. In addition, the Facility provided the PNMP and related acute care nursing plan. <u>Integrated Committees and Workgroups</u> The Facility had several committees and workgroups that brought together numerous disciplines for interdisciplinary reviews of individuals and systemic issues, including the following: • The Psychotropic Medication Oversight Committee (PMOC) continued to meet on a monthly basis, and it was the principal venue for Facility- wide review of medication practices and polypharmacy. Participation in the POMC included	

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		psychiatry, medicine, nursing, psychology, and quality assurance. The Facility-level review augmented reviews of polypharmacy that took place at the level of the IDT, where polypharmacy was reviewed in many venues. For example, individuals were reviewed for polypharmacy at PTRs (see discussion for provision J3, J9, J10), polypharmacy was part of the discussion about proposed new medications (see Provisions J9, J10, J13 and J14), and polypharmacy was also the focus of IRRF discussions including at the annual ISP meetings (see discussion under Provision J8). • The Skin Care Committee was comprised of interdisciplinary team members. Core membership included: Skin Integrity Nurse, Chairperson, CNE, NOO, Medical Director, Habilitation Representative, QA Nurse, Infection Control Nurse, Psychology Representative, QIDP Representative, Direct Support Professional Representative, and Dietitian. • The Medication Variance Committee continued to be chaired jointly by the Pharmacist Director and Nursing Operations Officer. The pharmacy director attended all Medication Variance Committee meetings, and reported on pharmacy related variances, and indicated corrective action steps for each variance reported. The medical director attended all Medication Variance Committee meetings. It was positive to find that the Director for Behavioral Service had become a member of the committee. Any medication variances, omission/extra doses related to psychoactive medication were reported to her to follow-up for changes in behaviors. She reported that one individual had missed some psychoactive medications and as a result the individual's behaviors improved. Then, the individual's medications were adjusted down with positive results. • Psychiatric Treatment Reviews (PTRs) remained the place where most of the routine psychiatric care was provided and was the place for routine monitoring of psychiatric diagnoses. Routine PTRs were conducted quarterly. Monthly PTRs continued to be held for children, and psychiatrists and could always add individuals to the scheduled quarterly PTRs on the basis of need. PTRs were attended by psychiatry, psychology, nursing, QDDPs, Direct Support Professionals (DSPs) and other disciplines, and sometimes by family members/guardians (via telephone). Primary Care Providers (PCPs) attended PTRs when their schedules allowed. If they were not able to do so the psychiatrist had an opportunity to consult with PCPs at many other venues, including the Medical Morning Report. The team process and collaboration between the behavioral disciplines remained strong at the key function of the PTR. • PBSC meetings provided an opportunity to review integration of behavioral health since the Head of Psychology led the meetings and the Head of Psychiatry	

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		attended. The Monitoring Team observed the PBSC meeting that took place on 10/08/13. The Chief Psychologist led the meeting, and the meeting was attended by members of her department including the IDT Psychologists for the individuals under review. Nurse case managers and QIDPs also attended the meeting. The actions of the committee members reflected a careful review of assessments according to behavior analytic principles. It was particularly noteworthy that comments offered by the psychiatric and speech-language staff reflected considerable familiarity with behavior analytic principles. <u>Integrated Planning and Services for Individuals</u> Integrated planning requires disciplines to work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The Facility continued to implement initiatives toward coordination among staff, including the development and monitoring of the IRRF, the Integrated Health Care Plans (IHCPs) and a variety of routinely scheduled cross-discipline meetings. As reported in Provision R2, the SLPs and psychologists continued to improve collaboration on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. Behavior Services and Speech continued to use a PBSP/Communication Assessment Checklist that was designed to improve consistency between the two documents and assist in identifying areas in which there is cross over between the two disciplines. There were numerous examples of interdisciplinary planning and integration of clinical services for individuals. For example: • As reported in Provision M1, acute care plans consistently included integration of care with other relevant disciplines. • As reported in Provision R2, the SLPs and psychologists continued to improve collaboration on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. • Behavior Services and Speech continued to use a PBSP/Communication Assessment Checklist that was designed to improve consistency between the two documents and assist in identifying areas in which there is cross over between the two disciplines. • For Individual #44, for whom discussion at the Morning Medical Debriefing was described above, there was an IDT meeting later in the day documented in an Individual Support Plan Addendum (ISPA). Disciplines represented according to the ISPA included the unit IDT—QIDP, nursing, habilitation therapy, direct support, home manager/supervisor, and psychology, and the team for the unit to which the individual may move—QIDP, nursing, habilitation therapy, psychology, and home supervisor. An action plan was developed, including	

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		transition assistance from staff at the current home during the first three days of the move to the new home, order for current shoes and appointment with the orthotics vendor, use of knee and elbow pads, and monitoring of possible medication side effects. A follow-up ISPA of 10/25/13 reviewed the move, the continuing incidence of falls (but without injury), the session at the orthotics vendor (which will require a follow up appointment with pre-treatment sedation), results of a gait assessment conducted by Habilitation Therapy, and recommendations for further action. As with the Morning Medical Debriefing, this indicated an integrated planning process. Further, it demonstrated that the IDT followed up on issues raised at the Morning Medical Debriefing. • The Monitoring Team reviewed Individual #89's ISPA reports and support documentation in the active record regarding meal refusals and G-tube placement, and found that the nurse was notified when the individual began to refuse meals and liquids. This continued to be documented by nurses and direct support staff. An OT/PT observation was conducted. The attending physician was informed of a weight loss and sent the individual to the hospital. The Hospital Liaison Nurse visited the individual. A decision was made for G-tube placement. Upon return home, the PNMT nurse completed an assessment. The IDT, including the QIDP, RN Case Manager, Habilitation Therapy staff, dietician, PNMT Nurse, and Home Manager met, and conducted a Change of Status risk review. Follow up continued from the physician, Habilitation Therapy staff, PNMT, and IDT. • There were excellent examples of communication and coordination of care between psychiatry, neurology, and medicine reported in Provision J15. These included Individuals #185 and #332. • There was evidence in communication assessments of review of the PBSP by the SLP, communication strategies were included in PBSPs, and ISPs included communication strategies identified in the SLP assessment. SLPs consistently were represented in meetings of the Positive Behavior Support Committee. • An individual in Cottage B was prescribed nectar-thickened liquids with pills given whole a few at a time mixed in pudding. While attempting to swallow a few pills mixed with pudding (of which one was a large calcium pill), followed by attempting to drink the nectar-thickened liquid, he then coughed a couple of times without struggle. The individual was immediately assessed by an RN according to the Respiratory Distress/Aspiration Protocol with no abnormal findings documented in the Integrated Progress Notes. The individual was referred to Habilitation Therapy for a medication observation to evaluate the size and texture of the pills administered. The Monitoring Team was provided Integrated Progress Notes and a copy of the referral to Habilitation Therapy to validate the actions taken.	

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		There were also examples that demonstrated the need for further improvement. For example: • Review of assessments prepared in advance of the ISP annual meeting for Individual #58 revealed a possible conflict. The communication assessment noted decreased cognition as a reason for poor prognosis for improving communication; the SLP did not recommend speech and language services to improve communication. However, the Behavior Assessment and Intervention Program (BAIP) reported that a Stanford Binet intellectual assessment of 8/15/12 was consistent with previous evaluations. It was unclear whether this was a conflict, as it this referred to a static level of cognitive skills or a recent regression. The Monitoring Team observed the ISP annual planning meeting for this individual. The discrepancy was not mentioned, there was no indication that either clinical discipline representative was aware of the discrepancy, and there were no recommendations for communication services. • As reported in Provision J8, case formulations for behavioral issues, typically between psychology and psychiatry, were generally adequate for the individuals reviewed at the Positive Behavior Support Committee meeting during this visit and in the sample of records reviewed. For case formulations overall, at times they were more of a case summary than a case formulation. Thus, there had been significant improvement, but further improvement was needed to move from summarizing the formulations of participating disciplines to developing a single formulation that incorporated the input from these disciplines. • As reported in Provision L1 for Individual #377 following fracture care, the medical provider did not participate at the IDT meeting for review and management of the fracture. PT/OT did not assess the Individual for necessary supports and services, secondary to the fracture. • As reported in Provision R3, three of 16 ISPs reviewed (19%) included how communication interventions were to be integrated into the individual's daily routine. Eleven of 16 ISPs reviewed (69%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not consistently developed to address identified concerns with communication. <u>Interdisciplinary Team (IDT) Attendance, Participation, and Clinical Planning</u> For integrated planning to occur, clinicians must participate in interdisciplinary meetings, such as the ISP annual planning session. During the ISP Preparation meeting, the IDT was to identify the requisite composition of the team for the purposes of the annual planning meeting and record this in the Attendance-Assessment checklist. BSSLC's Self-Assessment indicated the Facility had analyzed data from two	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>documents, an Attendance Tracking database from April through May 2013 and the ISP Process Monitoring database from June 2013 to July 2013, and found it showed overall attendance rates over 103 meetings stood at 87.7%. However, as reported in Provision F1b, other documents did not provide data since May 2013 due to difficulties with the new database implemented in June 2013. Furthermore, the Medical Director reported the data on attendance were not accurate, so she developed a separate report for medical providers, as described in the next paragraph. Review of signature sheets for all ISPs held during September 2013 revealed that attendance exceeded 90% for the following disciplines: Medical and Nursing. Attendance by Psychology/Behavior Analyst was 52% and by Speech/Language was 37%.

The Medical Director reported an emphasis among the medical staff on attending ISP annual meetings and completing annual medical assessments. The Presentation Book included a table from 4/15/13-9/13/13 of attendance by the primary care provider (PCP) at annual ISP meeting and of whether the assessment was “on time” or, if not, completed by the ISP meeting date. This was summarized by month. The information was from mid-month to mid-month. The table below is taken from the summarized information provided in this document. It shows a high level of attendance by medical providers. While it shows a 100% completion of annual medical assessments by the time of the ISP meeting, it also shows a need to improve completing these assessments 10 working days in advance so other IDT members can review them, compare the information to their own assessments, and identify how they may support each other or if there is conflicting information that needs to be reconciled in order to accurately identify status and needs, and plan services and supports. Refer to Provision V4 for additional information on completion of assessments; the Facility was not yet tracking these accurately, except for the tracking process and spreadsheet used to gather the information provided by the Medical Director for PCPs, but other information provided a similar finding of a need for improvement in timeliness to permit integrated clinical planning.

<table>
<tr><th>Month</th><th># of ISP meetings</th><th># PCP attended</th><th># assessments on time</th><th># assessments completed by ISP</th></tr>
<tr><td>April</td><td>15</td><td>14</td><td>8</td><td>15</td></tr>
<tr><td>May</td><td>28</td><td>27</td><td>18</td><td>28</td></tr>
<tr><td>June</td><td>23</td><td>23</td><td>15</td><td>23</td></tr>
<tr><td>July</td><td>30</td><td>29</td><td>23</td><td>30</td></tr>
<tr><td>August</td><td>23</td><td>22</td><td>17</td><td>23</td></tr>
<tr><td>September</td><td>13</td><td>12</td><td>7</td><td>6</td></tr>
<tr><td>TOTAL</td><td>132</td><td>127 (96%)</td><td>88 (67%)</td><td>119 (90%)</td></tr>
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		Attendance alone does not provide a complete picture of the participation by IDT members in integrated planning. Through observation of meetings, the Monitoring Team can note whether the planning process involves integrative practices. Although in general there was good interaction across team members, some observations indicated integrated planning, and others did not. Some examples include: • At a post hospital interdisciplinary team meeting for Individual #318, the primary medical provider gave detailed explanations of the individual's medical condition, hospital treatments, and medical issues that required enhanced services and supports. IDT members questioned the medical provider specifically about medical triggers, level of activity, activities of daily living, and the medical provider delineated meaningful recommendations. The IDT discussed specific signs, and symptoms of pain manifestations that would be monitored and established action plans. • At the ISP annual planning meeting for Individual #58, there issue of the relationship between falls and behavioral issues was appropriately raised, as running had apparently been associated with falls. However, the risk rating discussion did not relate the behavioral issues to a risk for falls, and no interdisciplinary discussion of this occurred. <u>Conclusion</u> Continuing improvement in collaboration and integrated planning were evident. The Morning Debriefing provided an excellent venue for integrated discussion and identification of issues needing collaborative planning; participation was clearly integrated, and disciplines used this as an opportunity to provide education and information to other disciplines. There were numerous interdisciplinary committees and workgroups. There were examples of excellent integrated planning, and other examples in which this needed improvement. Integrated clinical planning and services continue to evolve; to achieve substantial compliance, the Facility needs to continue to help staff identify inconsistencies among assessments and related services, to improve the consideration of how risks in one area of functioning and health may affect other areas and the services needed, and ensure assessments are timely so the information from one discipline can be considered by others when planning supports and services.	
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	<u>Policy</u> DADS Policy 009.2 Medical Care describes the responsibility of the attending primary care physician (PCP) to write initial consultation referrals and states "Routine medical/surgical consultation recommendations are addressed within five working days of receiving the consultation" and requires that there must be a clear explanation in the IPN if recommendations are not implemented. It also identifies IDT responsibilities to	Substantial Compliance

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	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.	document implementation of recommendations. Although the Facility did not have a policy that directly addressed review of consultations, it did have a document that provided guidelines, Procedural Guidelines for On-Campus and Off-Campus Consultations, which was consistent with DADS policy. Both the policy and the guidelines address only medical consultations. The Medical Director reported that all consultations require a medical order, including MBSS. They reported the only possible exception would be oral surgery consultations ordered by the dentist, but they were not aware of any that had been ordered. <u>Procedures and Forms</u> In response to a document request for "Forms used by any discipline to document review of and response to recommendations from non-Facility clinicians," the Facility stated, "We do not use a form as such. We write on the consult note itself and also write a note in the IPN (as described in G2 Procedural Guidelines for On-Campus and Off-Campus consultations (see XVIII 25)." These guidelines provided the steps in processes for on-campus and off-campus consultations with non-Facility clinicians. It described the requirement for the primary care provider (PCP) to write the order; the process for scheduling the consultation appointment; what documents were required, how consult reports would be received and provided to the PCP, documentation required from the PCP including sign off on the report within five business days of receiving the consultation (presumably, of receiving the report of the consultation, although that is not stated and could mean within five days of the consultation being done), writing a progress note that incudes whether the PCP agrees with the consultant's recommendations, recommending the IDT meet if advisable, and writing appropriate orders; reporting at the next Unit Morning Meeting and arrangements for an IDT meeting if required; and information the individual's Guardian/Family Member of results as appropriate. The guidelines also describe tracking and reporting, noting that there was not yet use of a database to track consults but was an expectation this would be developed soon. The guidelines stated the Facility had instituted an auditing system for a sample of consults to ensure adherence to the process, and notice in the "Medical Morning meeting" of any appointments missed. <u>Review of Consultations by Facility Clinicians</u> Facility Audits of Consultations: The Facility had begun a monthly process of audit of consults and provided information on consults audited. Information was gathered by auditing a sample of consultations, using a standard audit form. The information was reviewed by the Health Compliance Team, and actions were taken as needed. Minutes of this Team documented the evolution of this process, beginning in April 2013 with audits, followed by revision of the audit tool and plans to develop a database.	

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		The Facility provided information from the audits in narrative form with explanation of some issues that did not meet standards; data are summarized in the following table:	

Month 2013	# of consults audited	# (%) signed w/in 5 days	# (%) IPN	# (%) request IDT meeting	# (%) of IDT requests with documentation of meeting
July	16	12 (75%)	13 (81%)	5 (31%)	2 (40%)*
August	16	13 (81%)	14 (88%)	1 (6%)	0 (0%)
September	16	11 (69%)**	13 (81%)	0 (0%)	NA

* Narrative stated Nurse Case Manager reported a meeting was scheduled for one more
** Narrative stated one consult was dated 9/18 but faxed to Facility on 9/24 and signe 9/27. BSSLC guidelines require the PCP to review the "completed consult report" and sign off "within five business days." Presumably, that means within five business days of the report being received by the Facility, but that is not entirely clear. If so, this would have been found signed within five days but was not counted as such.

This process was too new to permit assessment of its effectiveness at improving compliance or helping the Facility to identify systemic actions to address problematic issues. However, it provides the Facility with a means to assess and track the level of compliance. Furthermore, the narrative indicated that the Facility gathered additional information on reasons for lack of compliance; this information could be useful in performing analysis and identifying corrective or improvement actions. Information from these audits should inform the Self-assessment for this provision prior to the next compliance visit. To be most valuable, these audits should sample all clinical consultations (such as MBSS and any oral surgery consultations in addition to medical consultations).

Review by the Monitoring Team: The Monitoring Team reviewed a sample of 14 medical consultation reports for 13 individuals (Individuals #27, #96, #111, #141 (x2), #259, #281, #288, #323, #325, #408, #473, #532, and #533), and five Modified Barium Swallow Studies (MBSS) for Individuals #159, #206, #255, #350, and #448.

- For the medical consultations:
  - Fourteen of 14 (100%) had evidence of review by a PCP.
    - Thirteen of 14 (93%) had evidence on the consultation form of review by a PCP (initials and date). Eleven (79%) had a progress note in the Integrated Progress Note (IPN) section of the Active Record.
    - Thirteen (93%) documented acceptance of the

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		recommendations either on the form or in an IPN; one did not document acceptance or rejection. • For the MBSS consultations: o Five of five (100%) documented review with a progress note in the IPN completed within five business days; the Monitoring Team did not check to determine whether the PCP had initialed the consultation report itself. o Five of five (100%) documented acceptance of the recommendations. • Overall: o Nineteen of 19 (100%) documented review by a Facility clinician, through either a notation on the consultation report or an IPN, or both. o Eighteen of 19 (95%) documented acceptance of recommendations. No consultation forms or IPNs documented referral to the IDT. However, the guidelines for consultations established a process for consultation recommendations to be read at morning unit meeting. The PCP is to sign off, give the signed consultation to the sick call nurse, who gives it to the Nurse Case Manager, who takes it to the unit morning meeting, where QIDPs and other IDT members are informed. Observations of unit morning meetings found instances in which this occurred. In addition, the standard agenda for the Morning Medical Debriefing included a section for "Review Follow Up Items." Items found on minutes reviewed by the Monitoring Team included IDT response to issues arising post discharge from hospital, review of actions taken to resolve individuals' health issue and the effect of those actions, and systemic actions such as training that should be done (for example, adding training on pain identification and management to new employee orientation). This would be a good place to include reports of IDT actions and Individual Support Plan Addenda (ISPAs) that address consultation recommendations and the effectiveness of those actions. <u>Conclusion</u> Because documentation of review and acceptance of recommendations was routinely found on consultation forms and in IPNs, and the minutes of Clinical Morning Report meetings documented examples of follow up with IDTs, this provision is found to be in substantial compliance.	

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:** 1. BSSLC Self-Assessment 9/23/13 2. BSSLC Action Plans 9/19/13 3. Presentation Book for Section H 4. DADS Policy 009.2 Medical Care 5/15/13 5. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/12 6. BSSLC Policy F.1: Individual Support Plan (ISP) Process, implementation date 10/26/12 7. BSSLC Policy H.1 Minimum Common elements of Clinical Care Ensuring Integration of Clinical Care 11/30/12 8. Standardized Assessment Templates, effective October 1, 2013 9. Minutes of the Health Compliance Team meetings of 5/14/13, 5/22/13, 7/26/13, and 8/21/13 10. Quality Assurance/Quality Improvement (QA/QI) Council report of 10/9/13 including Corrective Action Plan (CA) to address Change in Status 11. Clinical indicators provided for the following: a. Nursing b. Physical and Nutritional Management, including Pathway to Oral Intake c. Risk rating and the annual Integrated Risk Review Form (IRRF) **People Interviewed:** 1. Mary Ann Brett, MD, Director of Medical Services, and Penny Foerster, RN **Meeting Attended/Observations:** 1. Morning Medical Debriefings 10/8/13 and 10/9/13 2. Annual ISP planning meeting for Individual #58 3. ISP Preparation meeting for Individual #330 4. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section H. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section H, in conducting its self-assessment, the Facility: ▪ Did not use monitoring/auditing tools. The Facility might find it useful to implement monitoring and auditing of the comprehensiveness and quality of assessments, especially in light of the newly implemented standard assessment templates. Such audits should evaluate not only completion of required assessment sections but also quality of the content of the assessments. ▪ Did not use other relevant data sources and/or key indicators/outcome measures. Data were tracked and provided for timeliness of Physician and HAB Therapy assessments but not of other clinical disciplines (it should be noted that the Facility reported in interview that data for these

	assessments were hand-tallied, as the database was inaccurate, so the limited data should be viewed as a positive effort to begin to gather reliable data). These were the only data provided. For two provisions, the Facility reported the status of completing clinical indicators for several disciplines (Complete, Draft, or None). Once these are completed, the Facility should address whether they are clinically justified and adequate to assess status of healthcare for individuals and systemically, and whether treatments and interventions are modified in response to these indicators; such a review could involve data and/or use of monitoring and audit tools. ▪ The Facility rated itself as being in compliance with no provisions of Section H. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Complete or In Process. ▪ The Facility data identified some areas of need/improvement but did not consistently identify all areas needed for compliance. For example, the Self-Assessment identified a need for Provision H2 for timely completion of assessments but did not identify a need for diagnoses to clinically fit the assessments (and did not self-assess whether this was occurring). Even when needs were identified, the Action Plan did not consistently address them. For example, a need was identified in Provision H1 for timely completion of assessments; for Provision H3, the self-assessment reported there is no defined system to address this provision (which requires treatments and interventions to be timely and clinically appropriate based on assessments and diagnoses). The Action Plans for Provision H1 were to develop a system to track all required assessments and to monitor and develop corrective action as necessary. The Action Plan for Provision H3 was to "See H.1"; although ensuring treatments are based on assessments requires that information from current assessments is available, that would not ensure treatments were modified timely or appropriately. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. As evident from examples above, the Action Plans did not extend beyond initial steps needed to move toward compliance. A more complete plan would be valuable in guiding an organized process to achieve compliance.
	Summary of Monitor's Assessment: Overall, BSSLC continued to progress on meeting the requirements of Section H, although there were no provisions yet in which the Facility had achieved substantial compliance. A hallmark was the variability across disciplines in progress on a wide range of requirements, from timeliness and comprehensiveness of assessments to development and use of clinical indicators to timeliness of change in treatments and services based on clinical information. Provision H1: It was clear that actions had been taken, at least by some disciplines, to improve assessment timeliness and quality. Adequacy and timeliness of assessments and evaluations continued to be variable. Required assessments are determined at the ISP Preparation meeting, but Facility data on timeliness did not account for which assessments were or were not required; therefore, it was not possible for the Facility or the Monitoring Team to determine accurately the timeliness of completion. Overall, sampled

	assessments showed a need for continuing improvement, but some disciplines demonstrated consistent timeliness. No evidence was provided of systemic actions being taken to improve timeliness of assessments, other than efforts by the medical staff to ensure and track timeliness. There were several disciplines or areas of functioning for which progress had been made in improving content and comprehensiveness of assessments, but this remained variable. Completion of assessments in response to a change in status had continued to improve both in timeliness and content. Regarding use of information from assessments, examples were found both of use of information from assessments and of lack of use of the information. Provision H2: Diagnoses were generally consistent with the current versions of the DSM and ICD classification systems nomenclature, with the exception of seizure disorders. Although psychiatric diagnoses were consistent with DSM nomenclature, and the overall level of psychiatric evaluations is high, the quality of diagnostic formulations and underlying diagnostic justification is variable. There were several examples in which either diagnostic justification was not clearly stated, or there was no documentation of differential diagnosis and why alternative or additional diagnoses were not made. Provision H3: The Facility had continued processes to ensure treatments and interventions were initiated timely and based on medical diagnoses. Several sections of this report document continuing improvements in timely implementation of treatments and interventions but also document examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. Improvement was variable across clinical disciplines, and improvement is still needed. Provision H4: Development and use of clinical indicators to assess individual health care had continued. Two additional medical conditions had been added to the data tracking sheets for chronic medical conditions. The Nursing Department provided indicators identified in Nursing protocols. The Pathway to Oral Intake included data to be taken for each level of status/intervention. These were all positive findings. The Facility needs to implement procedures so these data can be available in a form that will provide trend data over time to clinicians to help them evaluate change or stability in health status. Other examples were found of the availability of clinical indicators. Provision H5: Although several actions to monitor health status of individuals had been continued, there had been little additional progress other than the addition of two conditions to the tracking sheets. The Facility continued the use of the Change of Status form to track referrals to the IDT from Sick Call and actions by the IDT. There was variability across disciplines and areas of service in the regular review of health status of individuals. Provision H6: The Facility had begun to develop and collect data on a set of clinical indicators. Tracking of change in data from indicators was not yet available, so modifying treatments and interventions in response to changes was dependent on the actions taken by clinicians and IDTs as they noticed changes. There were examples in which decisions about treatments and interventions clearly responded to clinical indicators, and there remained instances in which either clinical indicators were not considered in decision-making about treatments and interventions or in which information about indicators was

	inconsistent with such decisions. Provision H7: A facility policy to establish and implement integrated clinical services policies, procedures, and guidelines was in place. This policy covers most requirements of Section H. As reported throughout this Section and in other Sections of this report, not all requirements were yet fully implemented, although progress was continuing. Further policy development would be helpful, both at the Facility level and statewide.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Provision action information did not list any actions taken since last visit on any provision of this Section. Nevertheless, it was clear that actions had been taken, at least by some disciplines, to improve assessment timeliness and quality. <u>Policy</u> DADS Policy 004.1 continued the requirement that IDT members complete required assessments and place them in the shared drive for IDT review no later than 10 working days before the annual ISP meeting and no later than five days prior to the initial admission ISP. Requirements of B SSLC Policy F.04 Individual Support plan Process were consistent with DADS policy. <u>Extent to which assessments are conducted routinely</u> As reported in Provision F1d, assessment practices at BSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for QIDPs to complete the ISP Guide five days before the ISP annual meeting that would have enabled IDT members to review before the meeting, nor were assessments completed with sufficient thoroughness. Required assessments are determined at the ISP Preparation meeting, but Facility data on timeliness did not account for which assessments were or were not required; therefore, it was not possible for the Facility or the Monitoring Team to determine accurately the timeliness of completion. • In its Self-Assessment, the Facility reported its monitoring data for the period between April1, 2013 and July 31, 2013 indicated comprehensive assessments were completed on a routine basis and when there has been a change in status 19.7% of the time. • In a sample of ten recently completed ISPs reviewed for Provision F1c, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. Overall for this sample, the rate of timeliness was 72%. It was not possible to ascertain assessments that might be missing altogether for	Noncompliance

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		five of the individuals, as the ISP Preparation meeting documentation did not clearly prescribe the required assessments; therefore the timeliness compliance rate provided above is based on whether the assessments available in each packet were completed within the required number (either five or ten) of working days before the ISP meeting was held. • Audits of two active records found for Individual #532 that 73% of assessments or updates were present and timely; for Individual #533, who had been admitted since the last compliance visit, of 11 applicable assessments, four (36%) were completed at least five days prior to the initial ISP meeting, and six (55%) were completed within 30 days following admission. • As reported in Provision R1, for 11 of 11 individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. Eight of eight individuals in Samples R.1 and R.2 (100%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. • Information provided by the Medical Director and reported in Provision G1 documented that 67% of annual medical assessments were completed on time, and 100% were completed by the date of the ISP annual planning meeting. No evidence was provided of systemic actions being taken to improve timeliness of assessments, other than efforts by the medical staff to ensure and track timeliness. In fact, in response the a document request for a description of how the Facility monitors to determine whether assessments are completed and filed, the Facility responded "No evidence." During the compliance visit, a consultant from DADS reported the Facility plans to implement a database developed at another SSLC. Additional information for disciplines includes the following: • As reported in Provision O1, OT/PT assessments were consistently completed timely for both individuals in residence and individuals newly admitted. Assessments and updates were current within 12 months for individuals who are provided PNM supports and services. • Eleven of 11 admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. • As reported in Provision M2, from a sample of Admission/Annual Comprehensive Nursing Assessments and/or Quarterly Nursing Record Review/Quarterly Physical Assessments: o Three of three (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. o One of two (50%) Annual Comprehensive Nursing Assessments were	

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		completed 10 working days prior to the date of the ISP meetings. However, the other nursing assessment was completed but it was three days late. o Seven of seven (100%) Quarterly Nursing Record Reviews/Quarterly Physical Assessments were completed by the last day of the month in which the quarterly nursing assessment was due. For new admissions, most disciplines, but not all, completed assessments within 30 days following admission. • As reported in Provision J2, of 11 admissions to the Facility for individuals who took psychotropic medications prior to admission, all individuals (100%) were seen by psychiatry within 30 days. • As reported in Provision M2, four of four (100%) Admission Comprehensive Nursing Assessments reviewed were completed within 30 days of admission. • As reported in Provision P1, sixteen of 16 individuals admitted since the last review (100%) received an OT/PT assessment within 30 days of admission or readmission. • As reported in Provision R2, sixteen of 16 individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission. • Seven of 16 individuals admitted since the last review (44%) were provided with a Psychological evaluation report within 30 days of admission. Three individuals (19%) were not reflected in Facility tracking information as having been provided with a Psychological Evaluation report. The average span between admission and Psychological Evaluation for those newly admitted to BSSLC was 47 days. • For Individual #533, for whom the Monitoring Team conducted an audit of the Active Record, four (36%) were completed at least five days prior to the initial ISP meeting, and six (55%) were completed within 30 days following admission. The Facility could not provide information on timeliness of assessments. Information gathered by the Monitoring Team indicated that assessments were not yet consistently completed and posted in time for the members of the IDT to consider the information in the assessments when preparing for and participating in the annual ISP planning meeting. The Facility will need to: • Determine a way to track which assessments are required prior to annual ISP planning meetings in order to determine whether required assessments are completed timely, and whether any improvement actions need to be taken.	

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		• Ensure all disciplines required to provide assessments for new admissions due so at least five days prior to the initial ISP is developed. • Implement improvement and corrective action plans for identified concerns. <u>Comprehensiveness of Scheduled Assessments</u> Effective October 1, 2013, the Facility had begun using statewide standardized assessment templates for clinical assessments. These assessment templates included a set of standard sections that should be consistent from discipline to discipline. The topics appear to cover the needed areas that should be included. Within many sections, each template had specific information headings or boxes that needed to be completed. For example, the History section of the Biopsychosocial Assessment included a number of boxes for demographic information and for legal information, a place to list information on correspondents, a section for resident and family history with subheadings for Communication and Home Environment, Developmental History, and Trauma History. Other sections likewise included topics to specify the needed information. It will be important that the quality and comprehensiveness of the content of those sections be accurate and adequate for decision-making. Use of these templates had just begun, so evaluation of their quality and effectiveness in informing decision-making will await the next compliance visit. As reported in Provision M2, the Nursing Department had implemented recently revised assessment forms (which will evidently be revised again to match the standard format). Although the revised forms contained essentially the same assessment items, the Quarterly Nursing Record Review forms did not include a specific section for some of the information addressed/assessed on the former Comprehensive Nursing Assessment Form used for completing the quarterly nursing assessments. According to the guidelines these assessment items were to be summarized on XI: Nursing Summary on the Quarterly Nursing Record Review form. Instructions for the required contents of that section listed that information for inclusion. Currently, there were several disciplines or areas of functioning for which progress had been made in improving assessments, but this remained variable. • As reported in Provision P1, Comprehensiveness of assessments had continued to improve and was substantially compliant. • As reported in Provision R2, comprehensiveness of communication assessments had improved significantly. A few components were not yet consistently included, such as medications and side effects relevant to communication (although discussion of this was noted as part or integrated risk review) and comparative analysis of health and functional status relative to the prior year (which is a specific section in the revised communication assessment template).	

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		• As reported in Provision K5, psychological assessments were significantly more likely to include findings from current intellectual and adaptive assessments than found in prior compliance visits. There was concern that this progress might not continue, as the Facility understood that intellectual assessments were not to be completed without authorization from DADS; the Facility needs to clarify the accuracy of this perception. There were also examples in which assessment was not adequately thorough: • As reported in Provision L1 regarding osteoporosis, zero out of five examples (0%) included documentation indicating a clinical evaluation for the etiology of low bone density. • As reported in Provision T1e, assessments prepared for the Individual #52, whose CLDP was held shortly before the monitoring visit did not adequately address significant issues that could impact a safe transition to community living. Thus, comprehensiveness of assessments had improved in several areas but still required additional improvement. The Monitoring Team suggests the Facility review carefully the new assessments as they transition into the standard format to ensure all required components are included, and that the contents of the assessments include all components commented on in these compliance reports and demonstrate thoughtful and thorough assessment. <u>Assessments and Evaluations in Response to Changes in Status</u> Completion of assessments in response to a change in status had continued to improve both in timeliness and content. One way the Facility periodically assessed individuals for changes in status was through quarterly nursing and psychiatry assessments. As reported in Provision M2 for a sample of quarterly nursing assessments, all were completed timely. As reported in Provision J2, psychiatric treatment reviews (PTRs) were completed quarterly, with monthly PTRs held for children and individuals added to the scheduled PTRs on the basis of need. For 10 individuals in Sample O1 and O2 for whom the IDT identified changes needed to be made to the PNMP, ten ISPA meeting documentations (100%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. The Facility provided nursing assessments following each hospitalization. As reported in Provision M1, review of a sample of acute care plans showed that individualized plans were developed for each sampled individual and were incorporated into relevant	

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		protocols, and were consistently implemented. However, review of one individual with a pressure ulcer did not find revision to the acute care plan, although the physician was notified of findings, and further treatment was provided. Provision I1 (below) reported on a post-hospitalization Individual Support Plan Addendum (ISPA) meeting for Individual #318. This documented IDT review of risk ratings for change of status and identified a change in risk rating for pain, and an action for development of a plan to manage chronic pain. Provision I2 reported on review of a sample of records of individuals with a change in an at-risk condition (Individuals #86, #258, #413, #191, #264, #593, #483, #415, #591, #521, #251, and #106). There was documentation that the IDT consistently started an assessment process timely for each sampled record and identified those individuals for whom changes in circumstance required further assessment (for example, by the Physical and Nutritional Management Team). There were five (42%) examples of risk events or changes in status that warranted further assessment. There was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for all five (100%) individuals. The Facility, through the QA/QI Council corrective action plan (CAP) process, had developed a CAP to "improve the IDT process to appropriately address Change in Status." The QA/QI Council minutes of 10/9/13 included a CAP status report, with the CAP plan revised 10/3/13. It listed several actions and the timeframes for completion. The steps in the plan seemed thoughtful, appropriate, and sequenced. The first step, to develop a flow chart that describes the process for the IDT to follow, was listed as due 11/1/13. The Monitoring Team appreciates the development of such a plan and will review the progress and effect of this plan at the next compliance visit. <u>Use of Information from Assessments</u> Although clinical staff routinely reported in interviews conducted as part of records audits (see Provisions V3 and V4) that they used information from assessments in making decisions about treatments, services, and supports, there was also evidence that improvement was needed. Examples were found both of use of information from assessments and of lack of use of the information. The following provide examples in which use of information could be improved. Records did reflect that each individual had been provided with skill assessment by means of the Functional Skill Assessment (FSA). Unfortunately, it was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training. • Individual #76 was provided a SAP to place headphones correctly on his head so	

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		that he could listen to music and escape noisy environments. The FSA, however, did not reflect that the individual would participate in sound-based tasks. • Individual #106 was provided an SAP to teach the use of an electric razor to shave his chin. Although the SAP indicated that the SAP was based upon the FSA, the FSA reflected only the individual's skills in relation to using a manual razor. The Monitoring Team reviewed the assessments provided in advance of the ISP annual planning meeting for Individual #58 and observed the meeting. As described in Provision G1, there was a possible conflict between the psychology assessment and the communication assessment; the conflict potentially could affect decisions on supports and services. The Monitoring Team observed the ISP annual planning meeting for this individual. The discrepancy was not mentioned, there was no indication that either clinical discipline representative was aware of the discrepancy, and there were no recommendations for communication services.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Diagnoses were consistent with the current versions of the DSM and ICD classification systems nomenclature, with one exception. The seizure diagnosis for Individual #86 was "seizure disorder". The list developed and provided by the medical director of all individuals with known seizure disorder indicated a diagnosis of "generalized convulsive epilepsy, without mention of intractable epilepsy", or "generalized epilepsy"; however, on the annual medical assessments for individuals #361, #69, #428, #473, and #437, documented "seizure disorder", and not the specific diagnosis that was indicated on the list provided by the medical director. ICD-9 CM codes relevant to the diagnosis of seizure list many codes, none of which is "seizure disorder" but instead include disorders such as "Epilepsy and recurrent seizures," "Grand mal status," and "Partial epilepsy, with impairment of consciousness" or without impairment of consciousness. The Facility must document an accurate diagnosis for seizure disorder, and ensure that the Facility's list of individuals with seizure disorder is accurate corroborates the actual diagnosis. Regarding psychiatric diagnoses, all active problem lists (APLs) sampled by the Monitoring Team as reported in Provision J2 listed the current DSM diagnosis with correct terminology. There were no DSM diagnoses reported in Section J that were inconsistent with DSM terminology. While the overall level of psychiatric evaluations is high, the quality of diagnostic formulations and underlying diagnostic justification is variable. There were several examples in which either diagnostic justification was not clearly stated, or there was no documentation of differential diagnosis and why alternative or additional diagnoses were not made. Therefore, it is not possible to assess accurately that psychiatric	Noncompliance

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		diagnoses fit corresponding evaluations. The Facility reported that in August 2013, 44 of 140 (31%) of individuals followed by psychiatry had one or more "not otherwise specified" (NOS) diagnoses. Over the past six months one NOS diagnosis had been deleted. The Facility is aware of the fact that the number of nonspecific NOS diagnoses is high.	
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 Facility had continued processes to ensure treatments and interventions were initiated timely and based on medical diagnoses. Several sections of this report document continuing improvements in timely implementation of treatments and interventions but also document examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. Improvement was variable across clinical disciplines, and improvement is still needed. The Facility reported one process that has continued is the IDT referral system through Sick Call, the PTR, or direct referral to the IDT. A second reported process is review by the PNMT of every individual post-hospitalization. Finally, the Facility reported that medical policy requires individuals be seen by a primary care provider within 24 hours of a visit to the Emergency Room during weekdays and on the next business day on weekends. Examples of improvement included: • As reported in Provision O2, in five of five individuals' PNMT documentation reviewed (100%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. • As reported in Provision O3, for 10 individuals in Sample O.1 and O.2 for whom the IDT identified changes needed to be made to the PNMP, ten ISPA meeting documentations (100%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. • For individuals for whom the PNMP was revised, there was supporting documentation that ten of ten individuals' revised PNMPs (100%) had been implemented. • As reported in Provision L1, of five sampled examples of individuals with osteoporosis, five included annual medical summaries that indicated a clinically appropriate diagnosis for osteoporosis on the active problem list. In four out of five examples (80%) the annual medical summaries indicated a clinically appropriate action plan for osteoporosis. • As indicated in Provision H1 above, post-hospitalization assessment and development of care plans generally (although not universally) continued the	Noncompliance

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		improvement found at the last compliance visit. • The Monitoring Team reviewed three the records on individuals' with recently or currently active pressure ulcers, Individuals #332, #88, and #38. The Acute Care Plans for pressure ulcers showed significant improvement in the individualization, comprehensiveness, and quality. Findings for the review of Acute Care Plans included: o Two of three (67%) plans were initiated promptly upon identification of the problem. o Two of three (67%) plans were review and/or revised when indicated by change in condition or plans were not effective. Examples indicating a need for improvement included: • Although, as noted above, there was improvement in Acute Care Plans for pressure ulcers, there were also delays. o For Individual #88, there was an eight-day delay in initiating the Acute Care Plan for Impaired Skin Integrity Related to Pressure Ulcer Left Buttock. The plan should have been initiated promptly when the pressure ulcer was diagnosed. o For Individual #332, there was a 17-day delay in initiating the Acute Care Plan for Impaired Skin Integrity Related to Pressure Ulcer Right Buttock. The plan should have been initiated promptly when the pressure ulcer was diagnosed to ensure interventions were put in place to address and resolve the pressure ulcer. • As reported in Provision S1, there were examples in which completion of skill acquisition goals did not result in change of programs. o For Individual #288, the ISP reported on 7/4/2013 that the SAP needed to be continued. The individual had demonstrated mastery of the entire task in four of four trials in June and continued to demonstrate mastery through July. o Individual #483 had remained on the final step of his dental SAP during May, June and July 2013. The level of prompted necessary for success had increased in intensity throughout that period, to the point that prompts in July were primarily physical. There were no indications in the ISP or Monthly Reviews that this situation had been discussed. It was possible that the continuation of the SAP as originally written had acquired punishing qualities. The IDT should have been made aware of the individual's status so that arrangements could have been made for further assessment. • As reported in Provision K4, data for Individual #349 depicted several cycles of increased physical aggression and inappropriate sexual contact during the past	

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		year. These data suggested that the cycles were becoming longer and included behavior of increasing intensity. Documentation indicated that no changes in treatment had been attempted since December 2012. • As reported in Provision L1 for one sampled individual with a seizure disorder, the Individual was regularly followed by neurology. Nevertheless, the annual medical summary did not include a clinically appropriate medical action plan or comment on relevant issues related to seizure disorder, such as seizure frequency, efficacy of medication management, and necessary supports and services specific for seizure disorder. Overall, improvement continued in timely implementation of treatments and interventions, but there remained a need for continuing improvement.	
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.	Development and use of clinical indicators to assess individual health care had continued. The Facility reported that data tracking sheets for individuals are now maintained for eight conditions. As of the last compliance visit, these were maintained for constipation, diabetes, hypertension, lipid disorders, osteoporosis, and seizure disorders; since then, cerebral palsy and degenerative spine disease were added. The Medical Director reported the Facility is in process of setting up a database to record these data. The Facility provided a blank copy of the tracking sheet for each condition. The tracking sheets include the name of the individual, the home, gender, and specific information about the condition. For example, the tracking sheet for cerebral palsy includes the type, cause, a list of symptoms, whether the individual is followed by physiatry or is getting assistance from PT, OT, or Speech, any investigations that have been done (such as CT scan or EEG), medications, and comorbid conditions. For constipation, the tracking sheet includes medications for constipation, dietary measures, whether there is a bowel log, whether the individual is ambulatory, whether the individual has had a colonoscopy or has a history of impaction or bowel obstruction, and comorbid conditions. These tracking sheets provide a format for documenting important information. Five of eight (63%) include clinical indicator data other than listing symptoms, such as osteoporosis (DEXA scan results and pertinent lab values) and seizure disorder (pertinent lab values and seizure record x 3 months). These provide a good source of data that could be organized and reported over time both to document current status and any change for individuals and to identify and report on indicators that would provide good information about the status of health care Facility wide. The Facility should take the next step to make this information most useful for both care of individuals and identification of areas for system improvement initiatives.	Noncompliance

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		The Facility provided a list of clinical indicators to be considered when the IDT completes the IRRF and, presumably, to use to identify changes in risk status throughout the year. As reported in Provision I1, there had been considerable training of staff involved in risk identification. The Nursing Department provided indicators identified in nursing protocols for 20 separate conditions. These were generally descriptions of what needed to be assessed and documented, when and for how long they needed to be assessed and documented, and what actions needed to be taken based on the indicators. These were specific to individual care and did not reference maintaining data in a format that would permit review for systemic action. They were comprehensive and should help nurses make sure to assess and document essential signs and symptoms. The documents provided as clinical indicators for physical and nutritional management (PNM) were the Section O guidelines and the Pathway to Oral Intake. The Section O guidelines, while useful, did not address specific clinical indicators but did provide guidance on the actions needed in a number of PNM areas. On the other hand, the Pathway to Oral Intake listed, for each level of status/intervention, data to be taken. Given the range of data elements listed (all of which may be useful in assessing the status and effectiveness of treatment for an individual), it would be helpful to establish a process for consistent documentation. If that was available, it was not presented to the Monitoring Team. Nevertheless, this document not only provides guidance on a sequenced path toward oral intake but also provides a list of clinical indicators that can be used to assess status and guide treatment planning. As noted in Provision O2, plans resulting from PNMT recommendations for Sample O.2 included, for five of five individuals (100%), the specific clinical indicators of health status to be monitored. Other examples of the use of clinical indicators in planning individual care, or the need to improve the use of clinical indicators for individual care, included: • Review of Integrated Health Care Plans (IHCPs) indicated sample IHCPs consistently addressed high-risk health/mental health indicators. • As reported in Provisions J2 and J3, there were examples of the use of specific clinical information and data for decisions about diagnosis and treatment in PTRs. o In PTR meetings, the psychologist provided behavioral tracking data that informed the psychiatrist and IDT's decisions about medication management. That information was later summarized in PBSP reports. o In the April 2013 PTR for Individual #536 there was attention to the individual's sleep difficulties that were the basis of the diagnosis of	

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		primary insomnia. o Individual #149 had been diagnosed in the past with schizophrenia (see discussion for Provision J6 regarding the removal of that diagnosis as unsupported). A decision was made to continue to collect monthly psychosis ratings which • As reported in Provision K4, although not yet to a level of substantial compliance, there had been a significant increase in the availability of targeted and replacement behavior data collection sufficient to assess progress. • As reported in Provision R3, for five of five records (100%) reviewed of individuals receiving direct speech services, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For individuals with PNM difficulties, seventeen of 17 individuals' records (100%) in Samples O.1 and O.2 included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. Overall, this information showed improved consideration of clinical indicators for care and treatment of individuals. There was little indication that clinical indicators were selected and processes put into place either for consistent selection and tracking of clinical indicators to assess trends in health status for individuals or trends in healthcare status for the Facility as a whole. To move toward substantial compliance, the Monitoring Team recommends the Facility implement initiatives to make such trend data readily available to clinicians providing services to individuals and for consideration of planning to improve healthcare services.	
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.	Although several actions to monitor health status of individuals had been continued, there had been little additional progress other than the addition of two conditions to the tracking sheets. <u>Process for Change of Status</u> The Facility continued the use of the Change of Status form to track referrals to the IDT from Sick Call and actions by the IDT. • A Clinical IDT Referral form for Individual #490 was attached to the minutes of the Morning Medical Debriefing of 10/9/13. This form included the reason for being seen, a check whether this was or was not a change in status (yes was circled), a check for whether the team needs to meet (both yes and no were circled), a list of conditions for which this might be a change in status (none were checked), dates when the form was received and entered and when the QIDP was notified (10/10/13), and a place to note when IDT minutes are received (blank). Also attached were minutes of an IDT meeting of 10/29/13	Noncompliance

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		addressing the referral and also addressing other issues discussed at the 10/9/13 Debriefing meeting. • As reported in Provision M1, the Facility continued to use the Clinical IDT Referral Form in morning sick call. Nursing administrative staff reported in interview that, after the individual was seen by the PCP, if a Change of Status was determined the referral form was completed, entered into the designated database. The QIDPs reviewed the database and set up an ISPA meeting to address individual's Change of Status. Health Compliance Team Meeting minutes of August 21, 2013, stated there "have been issues with the change of status process and tracking resolution if the team has recommendations." The Quality Assurance Director "is going to review the audit tools and the data to come up with a resolution to these issues." As reported in Provision H1 above, a QA/QI Council had developed a CAP to "improve the IDT process to appropriately address Change in Status." The QA/QI Council minutes of 10/9/13 included a CAP status report, with the CAP plan revised 10/3/13. It appeared the Facility had identified issues for improvement in the change of status process and was taking action to improve. <u>Maintenance of a system to monitor health status of individuals</u> • The Monitoring Team reviewed the clinical indicator tracking sheets noted in Provision H4. These provide a good source of data that could be organized and reported over time both to document current status and any change for individuals. To move toward substantial provision with this provision, the Facility should implement processes to make information on health status and change or stability in status over time available to primary care providers. Evidence of regular reviews of health status of individuals indicated variability. • As reported in Provision L1, the Medical Director informed the Monitoring Team that medical providers do not perform quarterly physical assessments; and there was no documentation to indicate that medical providers routinely assessed the Individual to ensure that all necessary supports and services were in place and efficacious in helping to mitigate episodes of pneumonia. • As reported in Provision O7, zero of the 17 individuals' records in Samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QIDP monthly reviews only stated that services were provided and provided no information regarding status of the individual or if the individual had any issues related to	

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		PNM or if the plan had been revised over the past month. • As reported in Provision J2, routine PTRs were conducted quarterly (monthly for children), and psychiatrists and could always add individuals to the scheduled quarterly PTRs on the basis of need. • As reported in Provision K4, the Facility reported that the review of all BAIP data and progress notes by BCBAs that had begun in March 2013 had continued. Tracking tools reflected that nearly 100% of all notes and data were reviewed each month. In addition, ratings made by the BCBAs as part of the review reflected on-going improvement in the quality of progress notes and data. • As reported in Provision N2, there had been a lapse in timeliness of Quarterly Drug Regimen Reviews (QDRRs), but that had been corrected. QDRRs were of high quality; QDRRs were reviewed by primary care providers and psychiatrists in most cases but could still be improved.	
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.	As noted above, the Facility had begun to develop and collect data on a set of clinical indicators. Tracking of change in data from indicators was not yet available, so modifying treatments and interventions in response to changes was dependent on the actions taken by clinicians and IDTs as they noticed changes. As reported in Provision F2d, which requires the IDT to meet if a significant change in the individual's status has occurred to determine if the ISP needs to be modified, and make the modification as appropriate, the Monitoring Team found there were a number of examples in which the IDT should have taken assertive action to address the needs for services, supports and protections but did not. There were examples in which decisions about treatments and interventions clearly responded to clinical indicators, such as: • As reported in Provision O2, discharge summary/action plans for five of five individuals discharged from PNMT oversight (100%) provided objective clinical data to justify the discharge. • As reported in Provision L1, clinically appropriate diagnostics were obtained, and therapy provided based on the information from those diagnostics, for osteoporosis. However, there remained instances in which either clinical indicators were not considered in decision-making about treatments and interventions or in which information about indicators was inconsistent with such decisions. For example: • As reported in Provision K4, data for Individual #349 depicted several cycles of increased physical aggression and inappropriate sexual contact during the past year. These data suggested that the cycles were becoming longer and included	Noncompliance

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		behavior of increasing intensity. Documentation indicated that no changes in treatment had been attempted since December 2012. • As reported in Provision O7 for sampled individuals with PNM difficulties, zero of 17 records contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QIDP monthly reviews only stated that services were provided and provided no information regarding status of the individual or if the individual had any issues related to PNM or if the plan had been revised over the past month. • Although for individuals with PNM difficulties, seventeen of 17 individuals' records included evidence that the team discussed the need for and developed individualized triggers, only four of 15 trigger sheets sampled (26%) were completed correctly, and only ten of 15 Trigger sheets (67%) were reviewed at a minimum daily by the appropriate shift RN. Therefore, available data from individualized clinical indicators could not be used routinely to make decisions on change of status or the need to revise treatments and interventions. • For zero of six individuals discharged from direct OT/PT intervention (0%), termination of the intervention was well justified and clearly documented in a timely manner. • As documented in the previous monitoring report, Individual #286 had experienced a number of falls, which had not been adequately evaluated or addressed by the IDT. During the April 2013 monitoring visit, another fall had sustained significant injuries requiring hospitalization. Falls are often an indicator for a number of different conditions. In zero out of five sampled cases (0%), there was documentation on the annual medical summary, quarterly physician reviews, PT/OT assessments, and ISPs, indicating that prescribed supports and services to help prevent falls and fractures were routinely assessed for efficacy.	
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.	A draft DADS state policy addressed provisions G and H together. Although this policy had been initiated in November 2010, it had not yet been completed and implemented. BSSLC Policy H.1 Minimum Common elements of Clinical Care Ensuring Integration of Clinical Care, implemented 11/30/12, established integrated clinical services policy. This policy defined minimum common elements of clinical care. The definition included that care is provided timely in accordance with assessments and/or evaluation provided by all clinical disciplines, in accordance with diagnoses derived from the assessments or evaluations and comply with DSM and ICD nomenclature, and that interventions will be clinically appropriate and timely. The policy continued by identifying:	Noncompliance

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		• Requirements for assessments or evaluations by the Pharmacist, Nursing, the PCP, the Psychiatrist, the Psychologist, Habilitation Therapy, Speech-language pathology staff, the Audiologist, and dental staff. • The requirement for diagnoses to be consistent with corresponding assessments or evaluations and with DSM and ICD nomenclature, and to be documented in the APL, annual medical assessment, and PTR or CPE. • That treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses. Specific requirements were established for nurses to respond to acute changes in status, for PCPs to complete assessments if indicated, for other clinical disciplines to respond to acute changes, for nurses to complete a detailed assessment on each individual following discharge from a hospital, for the PNMT nurse to perform a post-hospitalization evaluation and for the PCP to perform an assessment for a hospitalization involving PNM problems, for the Psychiatrist to collaborate with the Psychologist and IDT in developing non-pharmacologic interventions for management of behavior issues, and for the dental staff to perform an evaluation if requested by the PCP or nurse. • That clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner, with all clinical disciplines developing and tracking clinical indicators for acute and chronic healthcare conditions and providing and revising interventions as indicated. • That each discipline department collects data to monitor services and individuals' care, and analyzes those data to identify opportunities for improvement. This policy covers most requirements of Section H. As reported throughout this Section and in other Sections of this report, not all requirements were yet fully implemented, although progress was continuing. The Facility might consider including in policy and procedures some of the actions that have improved integration of planning and development and use of clinical indicators, such as the Morning Medical Debriefing and the development of tracking sheets for chronic conditions and inclusion of clinical indicators in nursing protocols and the Pathway for Oral Intake, in order to formalize these processes and promote consideration of similar use of data in other areas. The Facility should also speed the process of developing databases and systems that track diagnoses and indicators individually and aggregate them to assess systems and identify areas for improvement. To move toward substantial compliance, the Monitoring Team repeats a recommendation from the last compliance report. Currently, the policy assigns	

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		responsibility for establishing clinical indicators of efficacy and monitoring of those indicators to each discipline department. Although these departments should have primary responsibility for those actions because of their clinical knowledge and their responsibilities for monitoring progress, the Facility should consider how to make this process more interdisciplinary (because the status of individuals in relation to specific health and clinical issues may affect status in other health areas).	

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (9/23/13) 2. BSSLC Action Plan (9/19/13) 3. Section I Presentation Book (undated) 4. DADS Policy 006.3 At Risk Individuals (12/7/12) 5. BSSLC Policy I.2 At-Risk Individuals 2/1/13 6. BSSLC Policy P.1 Habilitation Therapy Services 8/5/13 7. BSSLC Policy P.2 PNM Plans 7/13/12 8. BSSLC Policy O.1 Physical and Nutritional Management Team 11/27/12 9. Record reviews: Sample O.1: Individuals #15, #38, #41, #59, #89, #138, #153, #187, #243, #305, #392, #493, #539, and #597 10. Record reviews: Sample O.2: Individuals $41, #88, #89, #112, and #293, 11. Record reviews: Sample O.3: Individuals #37, #87, #186, #253, #428, and #570 12. Records reviews for compliance analysis for Individuals #59, #305, #187, #243, #15, #153, #258, #413, #591, #251, #533, #215, #533, and #148 13. Integrated Risk Rating Form and accompanying Risk Action Plan for Individuals #86, #258, #413, #191, #264, #593, #483, #415, #591, #521, #251, and #106 14. Record reviews Individuals #167 and #190 **People Interviewed:** 1. Kori Kelm, Director of Habilitation Therapies 2. Tracy Searles Physical Therapy Assistant (PTA) **Meetings Attended/Observations**: 1. Quality Assurance/Quality Improvement Council 10/9/13 2. ISP annual planning meeting for Individual #58 3. ISPA post hospitalization meeting for Individual #318 4. PNMT meeting 10/8/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included the DADS Section I Statewide Monitoring Tool. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.

	○ The monitoring tools included adequate methodologies, such as observations, interviews, and record reviews. ○ The Self-Assessment identified the sample(s) sizes, but did not include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). Sample sizes were adequate to consider them representative samples. ○ The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The self-assessment did not identify staff/positions that were responsible for completing the audit tools. ○ The Monitoring Team could not determine if staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). ○ The Monitoring Team could not determine if adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ The self-assessment did not report data on many areas of required compliance (refer to Provision I.3) ▪ Used other relevant data sources and/or key indicators/outcome measures, primarily the risk database. ▪ The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Presented findings based on specific, measurable indicators. ○ Measured the quality as well as presence of items. ○ Did not distinguish data collected by the QA Department versus the program/discipline. From the self-assessment it did not appear the Facility QA department conducted any Section I monitoring. ▪ The Facility rated itself as not being in compliance with any provision of Section I. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as in process, complete, or not started. ▪ The Facility data identified areas of needed improvement, primarily additional staff training. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section.
	Summary of Monitor's Assessment: The BSSLC processes to demonstrate compliance with this section of the SA had improved significantly from that reported in the last review. The most notable improvements continued to be in the areas under supervision of the Habilitation Therapies Department. Additional improvements were noted in areas under the supervision of the Nursing Department. The Facility is further along in fully implementing its At-Risk Individuals policy to guide the risk

	assessment process. Even though the risk assessment and mitigation process works more effectively with some disciplines than others and with some interdisciplinary teams (IDTs) better than others, the Monitoring Team noted overall improvement. Having written policy and procedural direction appears to have resulted in more consistent performance across the Facility. Most compliance rates improved significantly from that reported in the last review. Many were close to achieving substantial compliance. Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP meeting it attended, further improvements are needed. This is especially true in the use of clinical data in making determinations of risk.

#	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 statewide risk assessment procedure, with guidelines for rating risk, was in use at the Facility. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred and, as reported in Provisions I.2 and I.3, there had been a significant improvement in compliance scores. As noted in its last report, the Monitoring Team noted that the Facility developed an At-Risk Individuals policy (2/1/13, shortly before the last compliance visit) to guide the risk assessment and review process. Implementation of this policy had apparently resulted in improved performance related to compliance with this section of the SA. From data presented under Provisions I.2 and I.3 the implementation of this policy appears to be achieving improved practices associated with this section of the SA. The Monitoring Team observed one ISP meeting specifically to assess the risk assessment process. Staff present at the ISP were the actual staff who worked with the individual and were knowledgeable about the Individual. The Individual was present at the start of the meeting. The IDT used the Risk Level Guidelines required by State policy. The ISP meeting observed by the Monitoring Team included an open discussion among IDT members including presentation and discussion of clinical data but not all data was adequately presented, evaluated, assessed, and/or discussed. For example data was not used/reviewed when discussing the Individual's issues with falls and risk of fractures or the Individual's challenging behavior. There was insufficient discussion or contribution across all team members regarding the risk ratings especially with regard to clear issues facing the Individual such as falls and risk of fracture. Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP meeting, the risk levels assigned to the individual during the meeting could not be presumed to be accurate due to the lack of thorough discussion of specific risks and the absence of important data. This was especially evident when a low risk was assigned to fractures	Noncompliance

#	Provision	Assessment of Status	Compliance
		when the Individual had repeated falls. The Monitoring Team observed one post-hospitalization ISPA meeting. All relevant IDT members attended and actively participated at the meeting. Individual #318 was admitted to the hospital on 9/27/13 with a diagnosis of left pleural effusion. During her hospital course the pleural effusion was relieved by a thoracentesis and later by a thorcoscopic decortication. Individual #318's attending physician led the meeting. The physician did an excellent job describing and explaining her hospital course, health status at discharge, and health care needs upon discharge. He explained that she may experience chronic pain due to the decortication of the lung. The IDT reviewed Individual #318's risk ratings for Change of Status. It was determined that all relevant risk ratings were already rated as high. The team discussed the need for additional or changes in supports and service upon discharge home. There was more discussion regarding the potential to have chronic pain. It was decided that because of the potential for chronic pain, this would indicate a Change of Status risk rating as medium for pain. Acute care plans were to be implemented for of pneumonia and skin integrity issues. An Integrated Health Care Plan was to be developed and implemented to manage chronic pain. Individual #318's active record was brought to the meeting and was periodically referred to during the meeting. Additional information and data regarding risk assessments and risk mitigation can be found in Sections J, K, L, M, O, and P of this report. Based on this review this Provision was not in compliance. Low compliance rates in some areas, as reported by the Facility in its self-assessment and as validated by the Monitoring Team in Provisions I.2 and I.3 indicate the "risk screening assessment and management system" required under Provision I.1 is not yet fully effective.	
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	Review of 12 records (Individuals #86, #258, #413, #191, #264, #593, #483, #415, #591, #521, #251, and #106) showed there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual being identified as at risk for 12 (100%) individuals. This was an improvement from what was reported (86% compliant) in the last monitoring report. The Facility self-assessment reported a compliance rate of 50% from its monitoring which was less than the previous self-assessment compliance rate of 60%. The Facility sample of 25 was for the period 2/1/13 through 7/31/13. The Monitoring Team sample focused primarily on more recent assessments (completed in August and September, 2013). This may explain the wide variances between self-assessment compliance rates determined by the Facility and Monitoring Team compliance rates noted in Provision I.3 of this report. The records of these 12 individuals were reviewed to determine if changes in	Noncompliance

#	Provision	Assessment of Status	Compliance
	days of the individual being identified as at risk.	circumstance should have resulted in changes to an at-risk assessment, rating, and plan. For seven Individuals (58%), the IDT determined through review that the changes in circumstance did not require changes in the at-risk rating, and mitigation plan. There were five (42%) examples of risk events or changes in status that warranted further assessment. There was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for all five (100%) individuals. Based on a review of records of five individuals (Individuals #153, #258, #413, #591, #251,) for whom assessments had been completed to address the individuals' at risk conditions, four (80%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was not the case for Individual #153. Some nursing assessments referenced above were deemed minimally adequate by the Monitoring Team. Specific examples of areas needing improvement are found in Section M of this report. One nursing assessment (Individual #153) was deficient in that the clinical data used to support the risk rating was not sufficient. Based on a review of records of five individuals (Individuals #59, #305, #187, #243, and #15) for whom assessments had been completed to address the individuals' physical and nutritional management at risk conditions, all five (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. The following provides an example of an assessment that was comprehensive: Individual #59 was admitted to the hospital following serious emesis and coughing. The IDT met and developed an appropriate post-hospitalization plan and reviewed and appropriately revised the IRRF. BSSLC continued to show an improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM. Seventeen of 17 individuals in Samples O.1 and O.2 (100%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). In seven of seven individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral or review to/by the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. Additional examples of sound administrative practices with respect to the at-risk process can be found in Provision O.2. Based on a review of records of three individuals (Individuals #533, #215, and #251) for whom assessments had been completed to address the individuals' at risk conditions, three (100%) included an adequate polypharmacy assessment to assist the team in developing an appropriate plan.	

#	Provision	Assessment of Status	Compliance
		Based on a review of records of three individuals (Individuals #533, #215, and #148) for whom assessments had been completed to address the individuals' at risk conditions, three (100%) included an adequate psychiatric assessment to assist the team in developing an appropriate plan. As reported in Provision M5, the Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. However, these processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance. For example: • Risk assessments consistently provided clinical data sufficient to accurately determine risk levels. • Risk assessments generally sufficiently provided information that helped to develop a plan to address risk ratings. • Although IHCPs indicated they were approved and implemented by the IDTs within 14 days, it was difficult to determine from the documents reviewed the dates the plans for all identified risk ratings were actually implemented. • IHCPs were not consistently clinically sufficient to meet the needs for all identified risk ratings. Other risk issues identified by the Monitoring Team are noted in Sections J, K, L, M, O, and P of this report. For example, as reported in Section K, two individuals (Individuals #167 and #190) had problems with chronic pica. The pica behavior had resulted in the ingestion of dangerous objects. Based on Facility documentation, several issues were apparent to the Monitoring Team in the Facility's efforts to address the pica behavior. For example: 1) the level of supervision for one Individual was reduced shortly after surgery was required for the removal of ingested objects, 2) the necessary assessments of and interventions for pica were not conducted for either Individual, 3) ISPs reflected inaccurate information regarding pica and the risk to the individuals. The ISPs reflected that there had been no incidents of pica during the year when surgery had recently been required because of pica. Additionally, the ISP noted that the mother was pleased with the progress resulting in the need for less supervision when the pica related risk remained at previous levels and may have increased and 4) as a result one Individual had experienced the removal of large portions of the digestive tract due to continuing pica behavior. Although there had been significant improvement, this Provision was not in substantial compliance because the IDT was not consistently responding to a change in status and adjusting risk action plans accordingly in all areas of risk.	

#	Provision	Assessment of Status	Compliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	Based on a review of 14 records (Individuals #59, #305, #187, #243, #15, #153, #258, #413, #591, #251, #533, #215, #533, and #148) there was documentation that the Facility: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in 14 (100%)) cases. The compliance rate reported in the last review was 64%. The Facility self-assessment did not report a compliance rate. ▪ Implemented a plan that met the needs identified by the IDT assessments in 12 (86%) cases. The exceptions were for Individuals #153 and #413. The compliance rate reported in the last review was 43%. The Facility self-assessment did not report a compliance rate. ▪ Included preventative interventions in the plan to minimize the condition of risk in 14 (100%) cases. The compliance rate reported in the last review was 50%. The Facility self-assessment reported a compliance rate of 57%. ▪ When the risk to the individual warranted (nine cases), the Facility took immediate action in nine (100%) cases. The compliance rate reported in the last review was 50%. The Facility self-assessment did not report a compliance rate. ▪ Integrated the plans into the ISPs in 14 (100%) cases. The compliance rate reported in the last review was 64%. The Facility self-assessment reported a compliance rate of 63%. ▪ In 12 (86%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. The exceptions were for Individuals #153 and #413. The compliance rate reported in the last review was 50%. The Facility self-assessment did not report a compliance rate. ▪ In 12 (86%) appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. The exceptions were for Individuals #153 and #258. The compliance rate reported in the last review was 36%. The Facility self-assessment did not report a compliance rate. ▪ Included the clinical indicators to be monitored and the frequency of monitoring in 12 (86%) cases. The exceptions were for Individuals #153 and #413. The compliance rate reported in the last review was 50%. The Facility self-assessment reported a compliance rate of 50%. Compliance rates improved significantly from that reported in the last review but in some cases are still insufficient to demonstrate substantial compliance with this provision. The "risk screening assessment and management system" required under Provision I.1 is not yet fully effective. Based on this review the Monitoring Team determined this Provision was not in	Noncompliance

#	Provision	Assessment of Status	Compliance
		compliance, although significant improvement had been made.	

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:** 1. BSSLC Self-Assessment (09/23/2013) 2. BSSLC Action Plans (AP) (09/19/13) 3. Presentation Book for Section J, including all information on actions taken to reach compliance, forms and procedures for monitoring status of the Facility relevant to this section, and other information to document compliance or progress 4. DADS Policy and Procedure 007.3 Psychiatry Services (05/01/2013) 5. DADS Policy and Procedure 001.1 Use of Restraint (04/10/12) 6. DADS Nursing Protocols: Pretreatment/Post Sedation monitoring and Post Anesthesia Care (2013) 7. Section J Audit Tool – State Office Format (used starting 06/13) 8. BSSLC Protocol for Reiss Screening (revised 08/2013) 9. BSSLC Corrective Action Plan (CAP) for Reiss Screen referral process (07/2013) 10. BSSLC Psychiatric Medication Treatment Plan (PMTP), second version (revised 08/2013) 11. BSSLC Consent for use of Psychotropic Medication for Behavior Support (revised 08/2013) 12. A list of individuals who received psychiatric care, including the current psychiatric diagnoses, the name of the treating psychiatrist, the psychotropic medications given to the individual, and the date of the Appendix B psychiatric evaluation 13. A list of individuals for whom the psychiatric diagnoses have been revised since the last compliance visit, 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) 14. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Psychotropic Medication Oversight Committee (PMOC), since the last compliance visit 15. A list of all Comprehensive Psychiatric Evaluations (CPEs) done since the last visit 16. Individual Support Plan (ISP) materials for Individual #58, for the ISP held on 10-08-13 17. Copy of the ISP Addendum (ISPA) shell for pretreatment sedation 18. Polypharmacy justifications for all individuals treated with psychotropic medication who have tardive dyskinesia (TD) 19. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 20. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2011 until the present 21. A separate list of individuals, for whom each of the following is prescribed: a. Anticonvulsant medications being used only for psychiatric indications b. Anticonvulsant medications being used only for neurological indications c. Anticonvulsant medications being used for both neurological and psychiatric indications d. Lithium e. Tricyclic antidepressants f. Trazodone

	g. Beta blockers being used as a psychotropic medication h. Clozaril/clozapine i. Mellaril j. Reglan k. Anticholinergic medications l. Benzodiazepines 22. A list of individuals who had medical support plans and dental support plans, to reduce the need for pre-treatment sedation 23. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation - oral or total intravenous sedation TIVA 24. A list of all individuals screened for TD with Dyskinesia Identification System (DISCUS) evaluations 25. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) side effects evaluations 26. DISCUS forms done over the past year that were rated "5" or higher 27. A list of individuals diagnosed with TD and the Active Problem List (APL) for each of those individuals 28. A list of neurology clinic appointments for five individuals with both psychiatric and neurological problems, and psychiatrist participation in the neurology clinic appointments. Individuals reviewed were #185, #332, #377, #411, and #588. 29. Behavioral Assessment and Intervention Programs (BAIP) for Individuals #42, #417, and #215 that were presented to PBSC on 10/08/13 30. Sample J1: Record Reviews for Individuals #62, #133, #149, #158, #187, #300, #305, #462, #517, and #536. The Sample was comprised of 10 individuals selected by the Facility and considered to be clinically stable on their psychotropic medications. Materials reviewed for each individual were a. Social History b. Most recent Psychiatric Evaluation (Appendix B format if done) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Most recent Positive Behavior Support Plan (PBSP) and Functional Behavior Assessment e. Most recent Individual Support Plan (ISP) f. Most recent Annual Medical Summary g. Most recent APL h. All Psychiatric Medication Reviews for the past six months i. All MOSES/DISCUS Side Effects Screenings for the past six months j. All Quarterly Drug Regimen Reviews (QDRRs) for the past six months k. Most recent Health Risk Assessment Rating – tool and team meeting sheet l. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors –copies of the plan to reduce risk (ISP addenda) m. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation n. Most recent Annual Nursing Summary o. Most recent Neurology Consultation p. The most recent Human Right Committee (HRC) review for each psychotropic medication prescribed to the individual

	31. Sample J2: Information on 16 psychotropic medications approved by the Human Rights Committee (HRC). These were for Individuals #13 (Abilify), #30 (Latuda), #42, (Ativan), #10 (Remeron), #52 (Topamax), #118 (Vyvanse), #144 (Clozaril), #159 (Risperdal), #167 (Ambien), #24 (Zyprexa), #250 (Zyprexa), #321 (Risperdal), #367 (Ativan), #403 (Klonopin), #423 (Zyprexa), and #568 (Ativan). For some individuals more than one medication was approved by HRC and in those cases the medication reviewed by the Monitoring Team was the first medication listed by the Facility for that individual. Materials reviewed included: a. Information from the clinical record (e.g., progress notes, psychiatric treatment reviews, ISPAs) that helped the Monitoring Team understand the reasons/clinical rationales for choice of the medication b. Integrated Progress Notes (IPNs), Psychiatric Treatment Reviews (PTR)s and other psychiatric notes that clarified the reasons the new medications were proposed c. Consent for use of the Psychotropic Medication d. Positive Behavior Support Committee (PBSC) and HRC review of the psychotropic medication proposals e. Revised Positive Behavior Support Plan (PBSP or BAIP) 32. Sample J3: Documents related to psychiatric and neurological care for individuals who took seizure medication for both neurological and psychiatric indications. These were Individuals #185, #332, #337, #411, and #588. Materials reviewed were neurology clinic visit notes and also any other chart materials selected by the Facility to help the Monitoring Team understand the underlying neurological and psychiatric matters that were discussed. 33. A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attend or might attend 34. A list and copy of any new forms used by the psychiatrists 35. Details on any changes in the employment of current psychiatrists and details regarding the employment of any new psychiatrists, including board status, whether contracted or employed, and number of hours per week 36. Description of administrative support offered to psychiatrists (e.g. secretarial and administrative scheduling of psychiatric consultations **People Interviewed:** 1. Terry Blackmon PhD Chief Psychologist (10-09-13) 2. Victoria Morgan, MD Lead Psychiatrist (10-07-13) 3. Daniel Dickson, Quality Assurance Director (10-07-13) 4. Mary Anne Brett, Medical Director (10-08-13) **Meetings Attended/Observations:** 1. 10-08-13 Positive Behavior Support Committee (PBSC) meeting 2. 10-08-13 ISP meeting for Individual #58 3. 10-08- 13 PMOC meeting 4. 10-08-13 Medical Morning Meeting
	Facility Self-Assessment: The Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) results of the self-

	assessment; and 3) self-rating. For Section J: In conducting its Self-Assessment, the Facility reported that the State Office Audit Tool for Psychiatry was being completed by psychiatry. The Facility reported that the Psychiatry Department had an internal system and database to track completed psychiatric evaluations. The number of completed evaluations was compiled and submitted for review in the Quality Assurance and Quality Improvement (QA/QI) Council meeting. The Psychiatry Department also had an internal system and database to track completion of annual psychiatric updates. The Self-Assessment reported that changes in DSM Axis I diagnoses were tracked by the Psychiatry Department and that in the future the use of non-specific NOS diagnoses would be evaluated as part of the Department's internal QA monitoring plan. During the visit the Monitoring Team met with the Lead Psychiatrist and the Director of Quality Assurance to review additional details of the QA's efforts for psychiatry. The Monitoring Team learned that all uses of the State Audit Tool were done by the Psychiatry Department, typically by the Psychiatry Assistant. The Monitoring Team also learned that the number of charts audited had increased and that one record each month is now audited by a psychiatrist. Measurements of inter-rater reliability are now in place and are reported to the QA Department. The Monitoring Team had also requested reports about psychiatry provided to the Facility Quality Assurance/Quality Improvement Council. The results showed that the State Tool audits often exceeded 80% compliance, including provision items for which the Monitoring Team found non-compliance on this visit. One reason for the different finding was that the State Audit tool addressed only whether required items were present. For many provision items (for example, J2, J4, J6, J11, J13, J9, J10, J14, and J15) the Monitoring Team placed considerable weight not only on the presence of the information, but also its quality. The Monitoring Team encourages the Facility to consider some form of peer review (either internal or with other DADS facilities) to have psychiatrists evaluate the quality on key items such as psychiatrists' justifications for DSM IV diagnoses, and whether appropriate measures are selected to assess medication treatment efficacy. In the meeting with the Lead Psychiatrist and Director of Quality Assurance (QA) the Monitoring Team was informed that monitoring was in place in Section C restraints for the completion of the restraint checklist. There was also monitoring for documentation such as the consent, for IDT discussion and for desensitization plans. Also, Section C monitored the Corrective Action Plan (CAP) for pre-treatment sedation. The QA nurse also conducted four audits each month for completeness of nurse monitoring for safety during medical restraint. Information from those reviews was not included in the Self Assessment for Section J. It would be helpful for future Self Assessment to be informed by the results of all available monitoring and audits. The Director of Quality Assurance also reported that the Pharmacy Department reviewed MOSES/DISCUS evaluations for completion and accuracy on a monthly basis. The QA Department pulled a sample of 5 for the QDRR process and to conduct a review of MOSES and DISCUS. The review of that data was aggregated and presented to QA/QI on a quarterly basis and that data was used in the development of corrective action plans. Here too, the Self Assessment for Provision J12 could be improved by information about the results of the internal QA measures. In the Self-Assessment the Facility did report ongoing tracking data for polypharmacy (including the

	number and percent of individuals treated with interclass and intraclass polypharmacy). That information was helpful. Overall, the Self Assessment was responsive to the items addressed by the Monitoring Team in the previous visit, and it presented data on both areas of strength and weakness. It was helpful when the Facility acknowledged lack of progress when it was aware of that circumstance (for example, the failure to start the process of ISPA monitoring for pre-treatment sedation). That allowed the Monitoring Team to provide feedback to the Facility early in the process and in this case, to learn about alternative plans made by the Facility. The Facility rated itself as being in compliance with the following provisions of Section J: J1, J9, J10, J11, J12, J13 J14 and J15. The Monitoring Team found Substantial Compliance for Provisions J1, J5, J10, J12, J14 and J15. Provisions J10 and J14 were found by the Monitoring Team to be newly in substantial compliance and Provision J5 has returned to that status now that agreed upon levels of psychiatry staffing have been restored. The Monitoring Team did not agree with the Facility about Provisions J9, J11, and J13. In each case progress was made but for the reasons outlined in the assessment of status section of this report, specified requirements had not yet been met. The Facility also provided as part of its self-assessment an AP that reported actions being taken to achieve compliance. As with the Self-Assessment, the AP items focused on the items identified by the Monitoring Team as in need of improvement. That was helpful. For example, Action Step #2 for Provision J2 acknowledged the need to assess for quality of CPE's and not only for their presence. However, the specifics of how this and other goals would be achieved were not spelled out.
	Summary of Monitor's Assessment: During the current review period Provisions J10 and J14 came newly into a status of substantial compliance with the requirements of the SA. Improvements were noted in the manner that information about treatment alternatives and risk vs. risk discussions took place. The absence of these had resulted in these two provisions being out of compliance and the implementation of the required elements allowed their transition into the status of substantial compliance. Provision J5 returned to substantial compliance status with a resumption of established staffing levels for psychiatry. Provisions J1, J12 and J15 continued to be in substantial compliance. Considerable progress was made for many provisions even though the relevant provisions had not yet come into substantial compliance with all provision requirements. Those areas of progress were for the following provisions: • There was much progress on Provisions J3 and J13 around the modification of Behavioral Data Sheets (BDSs) that have long been used by psychology to track challenging behaviors. Steps have been taken to adapt BDSs so that psychiatrists will also receive data needed to determine medication treatment efficacy. • Progress has been made on Provision J8 via improvements in the psychiatry/psychology collaboration about tracking for medication efficacy. • Progress has been made on Provision J9 via consistent use of the ISPA for new medications.

	• Progress has been made on Provision J11. Lower rates of polypharmacy have been maintained and psychiatrist continued to complete polypharmacy justification statements during PTRs. Since not all individuals who required psychiatric assessments had received them, Provisions J2, J6 and J7 could not be considered for substantial compliance, and further improvement was needed for Provisions J3, J4, J8, J9, J11 and J13.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications and Experience of the Psychiatrists</u> Since the last visit Dr. Karla Kuusisto has accepted the position of Staff psychiatrist. Drs. Morgan and Chacko continued as Lead Psychiatrist and Staff Psychiatrist, respectively. Drs. Chacko, Kuusisto and Morgan were all licensed to practice medicine in Texas and were all board certified in psychiatry by the American Board of Psychiatry and Neurology. Dr Chacko was also board certified in child psychiatry. All had the training credentials, licensure and experience required by the SA, as reviewed during previous reports. Medical Licensure in Texas and Board Certification in Psychiatry remained active for all psychiatrists. All three psychiatrists actively and appropriately participated in interdisciplinary processes, including IDT and ISP meetings. They also participated in Medical Department activities such as the Medical Morning Report, and in Facility- wide oversight activities such as PBSC, PMOC and P&TC. <u>Monitoring Team's Compliance Rating</u> On the basis of the above, the Facility remains in substantial compliance with the requirements of the SA.	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>Facility Use of Psychotropic Medications</u> Psychiatry provided support for 140 of 288 (49%) of the individuals who lived at the Facility. One hundred thirty two of the 140 individuals who received support by Psychiatry (94%) were treated with psychotropic medications. <u>The Process for Evaluation and Diagnosis</u> All individuals who received medications needed to have CPEs in place; CPEs were completed after the individual had a face-to-face examination with the psychiatrist. Prior to making a diagnosis, psychiatrists typically also reviewed records from the Facility and from other treatment settings. The psychiatrists also obtained information from family members. Psychiatrists obtained information that contributed to the diagnosis in the course of their day-to-day work in the various settings and meetings where individuals	Noncompliance

		were seen and their care discussed. At the time of the visit comprehensive evaluations were in place for 92 of 140 (66%) of the individuals who were supported by psychiatry. DADS 007.3 Psychiatry Services Policy (effective 05/01/2013) also required that for individuals with a CPE there must be an annual update. The Facility has recently started to do annual updates; thirty six such updates have been completed so far. See Provision J6 of this report on the SA Appendix CPEs and annual updates. PTRs remained the place where most of the routine psychiatric care was provided and was the place for routine monitoring of psychiatric diagnoses. Routine PTRs were conducted quarterly. Monthly PTRs continued to be held for children, and psychiatrists and could always add individuals to the scheduled quarterly PTRs on the basis of need. PTRs were attended by psychiatry, psychology, nursing, QDDPs, Direct Support Professionals (DSPs) and other disciplines, and sometimes by family members/guardians (via telephone). Primary Care Providers (PCPs) attended PTRs when their schedules allowed. If they were not able to do so the psychiatrist had an opportunity to consult with PCPs at many other venues, including the Medical Morning Report. The Monitoring Team reviewed PTR documents over the past six months for the 10 individuals in Sample J1. Review of the documents showed continued attention to the matter of psychiatric diagnosis in the PTRs. For example, in the April 2013 PTR for Individual #536 there was attention to the individual's sleep difficulties that were the basis of the diagnosis of primary insomnia. In the August 2013 PTR for Individual #158 there was discussion of the individual's scores on the Yale Brown Obsessive Compulsive Scale (YBOCS) rating that was related to his diagnosis of obsessive compulsive behaviors. The diagnosis of bipolar disorder for Individual #300 was a matter of ongoing discussion and in the PTR for July 2013 the psychiatrist discussed that when the individual was taken off an antipsychotic medication he had a marked decompensation in his behavior and his mood with evidence of psychosis. That supported the need to continue prophylaxis against another episode of psychosis. Individual #133 was diagnosed with major depression which was in remission but which had been accompanied in the past by psychotic features. In the PTR from March 2013 there was attention to his Brief Bipolar Disorder Symptom Scale (BDSS) rating for psychosis and the nature of his thought process generally. This was used to confirm the accuracy of his diagnosis. Similarly, Individual #517 was diagnosed with bipolar disorder and had a history of psychosis. There was a discussion in the July 2013 PTR about the need to monitor for symptoms of hypomania per that diagnosis. Individual #149 had been diagnosed in the past with schizophrenia (see discussion for Provision J6 regarding the removal of that diagnosis as unsupported). A decision was made to continue to collect monthly psychosis ratings which showed attention to information that could impact on the psychiatric diagnosis. Individual #187 was diagnosed with schizoaffective disorder. He is not experiencing any psychosis at this time but in the PTR of July 2013 the team psychologist reminded the team that when his antipsychotic medication was tapered years ago, the	

		individual became both psychotic and catatonic and responded to the reintroduction of the antipsychotic medication. This showed continued attention to the underlying psychopathology. Other Facility meetings also served as places where diagnoses were discussed. PBSC meetings provided an opportunity to review integration of behavioral health since the Head of Psychology led the meetings and the Head of Psychiatry attended. The Monitoring Team observed the PBSC meeting that took place on 10/08/13. The meeting was led by the Chief Psychologist, and the meeting was attended by members of her department including the IDT Psychologists for the individuals under review. Nurse case managers and QDDPs also attended the meeting. The focus of the PBSC was the review and approval of new or modified PBSPs, and for several individuals a clinical discussion about diagnosis was part of that discussion. For example, the diagnosis of Individual #417 (bipolar disorder) was examined after significant difficulties were noted when a change was made in her medications. There was also a discussion of the diagnoses of Individuals #305 and #238. The discussion of the latter two was related to a change in the Facility plan for annual review of key psychiatric information, including diagnosis. Previously, psychologists provided psychiatric information in PBSC meetings. The new procedure was that the psychiatrist provided a Psychiatric Medication Treatment Plan (PMTP) review annually, and brought that information for review to the PBSC. This was an excellent step as it led to improved communication between psychology and psychiatry about key matters, including diagnosis. The discussions about Individual #305's diagnosis of intermittent explosive disorder and Individual #238's diagnosis of autism took place as these two individuals' annual renewal of the PMTP were presented for PBSC review. ISPs also provided an opportunity for the IDT (including the psychiatrist) to come together with individuals and families to review progress and to plan future support. The Monitoring Team observed the ISP for Individual #58 on 10-08-13. The IRRF discussion included a review of challenging behaviors that were felt to be related to his diagnosis of obsessive compulsive disorder (OCD), and the treatment of that disorder with Zoloft. <u>Facility Efforts to Provide Evaluations and Track Key Information</u> CPEs in place: As above, 92 of the 140 individuals followed by psychiatry (66%) had CPEs in place. That was essentially unchanged from February 2013 at which time 93 of 140 (66%) of individuals treated by psychiatry had CPEs in place. Use of DSM diagnoses throughout the clinical record: The Monitoring Team reviewed the APLs of individuals in Sample J1. All APLs listed the current DSM diagnosis with correct terminology.	

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<td>The use of NOS diagnoses: The Facility reported that in August 2013, 44 of 140 (31%) of individuals followed by psychiatry had one or more NOS diagnoses. Over the past six months one NOS diagnosis had been deleted. The Facility is aware of the fact that the number of nonspecific NOS diagnoses is high. In the Self Assessment the Facility commented that this will need to be addressed through CPEs or annual updates. The Monitoring Team agrees with that assessment.

<u>Monitoring Team's Compliance Rating</u>
The Monitoring Team again witnessed that the diagnostic process at the Facility is supported by the inclusion of input from many disciplines, in many places. Overall, the level of psychiatric care was high and there were good interdisciplinary exchanges between psychiatrists and colleagues from other disciplines. However, the progress of completing CPEs had stalled as had the process to resolve NOS diagnoses. These need further attention and the Facility remained in non-compliance on this provision.</td>
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<td>J3</td>
<td>Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.</td>
<td><u>Treatment Plan Information on Psychiatric Diagnoses and Treatment</u>
The key requirement of the provision was that medications should not be used as a substitute for a treatment program. At the Facility, the behavioral treatment program was termed BAIP. For 28 of the 140 (20%) individuals supported by psychiatry, the main supports were psychiatric and for those individuals the treatment program was a Psychiatric Support Plan (PSP). The Facility reported that, as of 9/18/13, 20 individuals who took psychotropic medications did not have a current behavioral support program. Eleven of those 20 individuals (55%) had a draft of a plan that was awaiting final approval from PBSC.

PBSPs and PSPs reported on the psychiatric diagnosis and psychotropic medications given to individuals. The key place where decision making on psychotropic medications took place was the PTR meeting, attended by psychology and psychiatry along with other disciplines. In those meetings the psychologist provided behavioral tracking data that informed the psychiatrist and IDT's decisions about medication management. That information was later summarized in PBSP reports.

The template in use for PTR presentation at the time of the visit contained the following key elements:

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<td>Axis I Psychiatric Diagnosis</td>
<td>Psychiatric Symptoms (in the new PMTP – "targeted psychiatric symptoms")</td>
<td>Rating Scale (In the new PMTP "Treatment Efficacy Measure [data or scale]")</td>
<td>Psychotropic Medication</td>
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<td>Noncompliance</td>
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		The Monitoring Team reviewed Sample J1 to see if information in PTRs and in PBSPs was presented in the same format. The PTR format was found in eight of 10 (80%) of the individuals (materials for Individual #149 were pending and materials for Individual #462 were organized in a different format). The 80% figure was much higher than it had been in the past and the progress was significant because it meant that direct comparisons could now be made between the annual behavioral plan and its psychiatric data, and the PTR meeting where psychiatric information was reviewed and decisions on treatment were made. <u>Appropriate Use of Medication</u> To review Facility processes that monitor for appropriate use of medication, the Monitoring Team reviewed three different types of clinical meetings: • The Monitoring Team reviewed the PTR information from the individuals in Sample J1. PTR notes were 3-5 pages in length and included a dictation from the psychiatrist that not only reviewed diagnosis (see discussion under Provision J2) but also reviewed the treatments provided by psychology and others to assure that medication treatment was a part of the overall behavioral plans. As described under Provision J13, the Facility is in the process of starting a system to provide psychiatrists with measures to assess treatment efficacy based on agreed-upon behavioral metrics that include rating scales and behavioral characteristics that are individualized and defined. This system is not yet fully operational and little can be said at this point about appropriate use of medication that is data-based. • On 10-08-13 the Monitoring Team attended the ISP annual planning meeting for Individual #158 who was diagnosed with obsessive compulsive disorder (OCD). The psychiatrist provided detailed information about medications via the behavioral health section of the IRRF, and discussed how the individual's medication (Zoloft) attenuated symptoms of the OCD. • On 10-08-13 the Monitoring Team observed the PMOC, the Facility Committee that reviewed use of psychotropic medications generally, and in particular, polypharmacy. For details, see discussion under Provision J13. No evidence was noted that showed inappropriate use of medication. <u>Medications used for staff convenience</u> The Monitoring Team addressed whether medication was used for staff convenience by examination of the records, and by observations made during PMRs and other activities during the visit, and by interviews with staff. There was no evidence that medications were used for staff convenience. <u>Medications used for punishment</u> To determine whether this was ever done, the Monitoring Team considered observations made during the tour, and reviewed the records of the 10 individuals in Sample J1. There	

		was no evidence that medications were used for punishment. Chemical Restraint The Facility reported that there were three instances in which chemical restraints were used since the last visit (two since March 1 2013, and one in the six months prior to this compliance visit). Two of these were for Individual #248 who was newly admitted. The Monitoring Team reviewed the chemical restraint for Individual #367 on 04-29-13. Documentation provided to the Monitoring Team included IPNs that documented efforts to manage the individual's aggression with behavioral techniques, pre-restraint consult by the psychologist on call, orders from the medical attending for use of medication (Ativan), Crisis Intervention Restraint Checklist, and the Crisis Intervention Face-to-Face Assessment and Debriefing form. Dr. Chacko was contacted at the time and she completed the Administration of Chemical Restraint: Consult and Review Form in a satisfactory fashion. Summary and Monitoring Team's compliance rating There was no evidence that medications were used for staff convenience or for punishment. In regard to appropriate use of medication, progress was made in the reporting of psychiatric treatment information in the BAIP/PSP. In the future that reporting will include data on treatment efficacy. Such information on the psychiatric treatment will make possible a good understanding of the role of medication treatment in the overall treatment plan. As outlined in Provision J13 and in the comments above, the system for data-based determinations is not yet fully operational and more progress needs to be made for the Facility to be in substantial compliance for this Provision. In regard to appropriate use of medication, progress was made in the reporting of psychiatric treatment information in the BAIP/PSP. In the future that reporting will include data on treatment efficacy. Such information on the psychiatric treatment will make possible a good understanding of the role of medication treatment in the overall treatment plan. As outlined in Provision J13 and in the comments above, the system for data-based determinations is not yet fully operational and more progress needs to be made for the Facility to be in substantial compliance for this Provision. .	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to	Rates of use of pre-treatment sedation Twenty three of 180 (13%) dental procedures done in the clinic since 04/01/13 used TIVA. The Facility reported no use of oral pre-treatment sedation in the dental clinic. The Facility reported that between 04/01/13 and 08/31/13 there were 13 uses of medical pretreatment sedation. Both oral pre-treatment sedation and TIVA were considered to be medical restraints. Monitoring for safety during medical restraint	Noncompliance

	minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Facility procedures to monitor for safety during medical restraint procedures were described in DADS Nursing Protocols: Pretreatment and Post Sedation monitoring, and Post Anesthesia Care. The nursing protocols for safety spelled out that for oral pre-treatment sedation monitoring for safety included a baseline nursing evaluation that included a full set of vital signs, and mental status, gait, balance, and coordination. Vital signs measurements were then to continue every 30 minutes until departure from the home/unit. Upon return to the home from the procedure, monitoring was to continue every 30 minutes x2, then every 2 hours x2, then every four hours, for a minimum of 24 hours. For TIVA, the protocol required post TIVA assessment prior to release from the infirmary with vital signs every 15 minutes for an hour, then every 30 minutes until a REACT score (a measure of alertness) of 8 or higher was reached. At that point the individual could return to the home. Monitoring on the home was to continue every hour for two hours then every shift for 72 hours. During the last visit the Monitoring Team was informed that vital signs for TIVA procedures from hour 24 through 72 would be documented on post-sedation vital sign checklists. The Monitoring Team reviewed the procedures for safety for nine individuals. These were Individuals #76 (08-08), #101 (05-10), #102 (08-08), #120 (07-26, #237 (07-09), #250 (05-09), #297 (05-30), #366 (06-05), #436 (08-23), and #475 (08/09). Three of the procedures were for general medical procedures (two well woman exams and one eye exam) and six were for TIVA sedations for dental examinations. All procedures had appropriate consent; monitoring for safety according to Facility protocols was completed for four of nine (44%) of the examinations, partially complete (either multiple missed points of early termination) for another four of nine (44%), and in one of nine (11%) there was no documentation it was attempted. <u>Status of Development of Plans to Minimize the Need for Pre-Treatment Sedation:</u> One hundred and eighty individuals had dental procedures and of those, twenty-eight individuals (15%) had APs to reduce the need for dental pre-treatment sedation. Four individuals had APs to reduce the need for medical pre-treatment sedation. The Facility did not provide data on the number of individuals who had routine medical procedures for which pretreatment sedation might have been considered. During the last visit the Monitoring Team commented that the process was at an early stage and compliance will require an actual plan that included actions associated with the Individual's ISP and that there would be evidence the plan has been implemented (e.g. data sheets that can confirm the plan had been implemented as designed). For the current sample, plans to reduce the need for pretreatment sedation were present for two of nine individuals (22%) but no data was provided on any individual to show implementation of the plan. <u>Monitoring Team's Compliance Rating for Compliance</u>	

		During the visit the Facility informed the Monitoring Team that it had developed a plan to provide individuals who receive pretreatment sedation with programs to reduce the need for that sedation. Nurse monitoring with vital signs was provided but in many cases the monitoring did not follow the relevant state protocols. At this time the Facility is not in substantial compliance with the requirements of the SA.	
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>Psychiatric Staffing</u> At the time of the visit there were three psychiatrists at the Facility, Drs. Chacko, Kuusisto, and Morgan. Dr. Chacko worked 40 hours/ week, Dr. Morgan worked 20 hours/week, and Dr Kuusisto worked 40 hours per week. The total level of effort was 2.50 FTEs of psychiatric time. Administrative support offered to the psychiatrists was one psychiatry assistant that assisted with scheduling and preparing PTRs, tracked diagnostic changes at PTRs, prepared psychotropic medication consents and PMTPs for review by the psychiatrists, coordinated neurology clinics for psychiatrists, printed/copied/psychiatry documents and attended IDT meetings to obtain information as directed by psychiatrists; there was another psychiatry assistant who also scheduled PTRs and attended IDT meetings, assisted with the departmental database management, performed internal audits for psychiatry, compiled and sent out Axis I diagnostic change reports, coordinated PMOC meetings, prepared data reports for QAQI meetings and assisted the Lead Psychiatrist with meetings and activities related to the SA.. There was one behavioral health administrative clerk who transcribed PTR dictations, typed psychiatry reports, updated the psychology department database with information about psychotropic medications and provided PBSC administrative support. <u>Determination of Required FTEs</u> At the time of the last compliance visit the Facility determined that 2.5 FTEs of psychiatric time were needed to ensure the provision of services necessary for implementation of this section of the SA. The Monitoring Team agreed with that estimate. That determination took into account the amount of time needed to provide staffing for psychiatry clinics and other clinical responses needed across the campus, to provide admission evaluations and updates, to attend meetings such as POMC and P&TC and physician's meetings, ISPs, and ISPAs, and to respond to clinical/administrative issues that concerned psychiatry. Current psychiatric staffing is at the level of 2.50 FTEs. <u>Team's Compliance Rating</u> The Facility has returned the psychiatric staffing to the level determined necessary to fill the requirements of the SA and the Facility is now in substantial compliance with the requirements of the Provision.	Substantial Compliance

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> As of 02/28/13, the Facility reported that CPEs were in place for 92 of 140 (66%) of the individuals followed by psychiatry. That compared to 93 of 140 (66%) of individuals followed by psychiatry at the time of the last visit. <u>Review of Completed Evaluations</u> The Monitoring Team reviewed the psychiatric evaluations of the 10 individuals in Sample J1. They had been completed for six of 10 (60%) of the individuals. The Facility has now started to do annual psychiatric updates, and these were present for five of 10 (50%) of the individuals. CPEs reviewed were six to ten single spaced pages and they followed the recommended format. As a rule the sections on history of present illness, past history, family history, substance use, medical history, developmental information, social history, substance use, current medications, and mental status all exceeded required standards. The section on diagnostic formulation and diagnostic justification, however, needed continued attention and some improvement; the general guidelines on what is needed for that section is that the evaluation must justify each diagnosis in terms of all the relevant DSM criteria. Those requirements were not always met. To clarify what the Monitoring Team needed to see in terms of diagnostic justification, the following bullets review the justifications for each of the six individuals in Sample J1who had evaluations and where applicable, the annual updates of those evaluations. • Individual # 62 had a psychiatric evaluation on 11/23/11. She was diagnosed with pervasive developmental disorder (PDD), obsessive compulsive disorder OCD, attention deficit hyperactivity disorder (ADHD) and chronic motor tic disorder. The diagnosis of PDD was justified via the severe impairment in the development of social interaction associated with communication skills and the fact that she did not meet criteria for any specific PDD, schizophrenia or personality disorder. The individual's diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was justified via the individual's distractibility, difficulty sustaining attention in tasks and difficulty paying attention to detail.. The chronic tic disorder was evidenced by multiple motor tics, and Tourette's disorder was excluded. The psychiatrist wrote that the individual met criteria for OCD on the basis of compulsions of biting her cuticles, picking at her gums and her skin, increasing at the time of anxiety, and the psychiatrist described that the patient was at times so engaged in these behaviors that is was hard to refocus her on other tasks at hand. The Monitoring Team did not question the presence of repetitive behaviors, but these could have been accounted for by the diagnosis of PDD, and that was not discussed. Additionally, other DSM/DMID characteristics of OCD were not addressed. For these reasons the key diagnosis was not adequately justified. • Individual #536 had a psychiatric evaluation in 2011 and was diagnosed with	Noncompliance

		Disruptive Disorder NOS and primary insomnia. A diagnostic justification was not offered for either diagnosis. A psychiatric update was done in 2013 which resolved the NOS diagnosis via its removal. The diagnosis of primary insomnia was discussed in the text of the evaluation via a comment that he did not meet criteria for any mood disorder or psychiatric disorder that could account for the insomnia. It would have been better to have also discussed/ ruled out the possibility of a medical etiology for the insomnia, but the Monitoring Team accepted the diagnosis as justified nonetheless. • Individual #158 was evaluated in 2011 and diagnosed with OCD. There was no justification section in the evaluation but in the history of present illness there were descriptions of ritualistic behaviors such as checking things and following a certain order when turning on the cold and hot water. Other symptoms were noted such as restlessness, appearing anxious, hitting himself in the face with his cap and appearing sad. Given all those symptoms more discussion/justification was needed for the selection of the sole diagnosis of OCD to explain his psychiatric symptoms. There was a psychiatric update in 2013 but the diagnosis was not further addressed. • Individual #300 had a psychiatric evaluation in 2011and was diagnosed with Bipolar Disorder (BPD) and trichotillomania. There was no specific discussion of why that diagnosis was chosen, but the lengthy evaluation described symptoms of agitation, self- injury, public masturbation and bizarre statements like "Momma threw me in the trash can" and "people on drugs." The evaluation described various diagnoses that had been used over the years including mood disorder secondary to head injury. There needed to be discussion of why Bipolar Disorder was diagnosed and how the relevant diagnostic criteria were met. That was not present. There was a psychiatric update in 2012 that did provide examples of characteristics of the bipolar disorder including aggression, screaming, decreased sleep, excessive masturbation, pressured speech and the bizarre statements listed above. These were certainly consistent with bipolar disorder, but many other disorders too. At least one of the evaluations should have included a discussion of the differential diagnoses, why bipolar disorder was preferred, and how the relevant diagnostic criteria (including cyclicity) were met. • Individual #305 had a psychiatric evaluation in 2011. The evaluation described agitation, aggression and irritability and that when the individual wanted something, he wanted it right away. He was diagnosed with intermittent explosive disorder and severe mental retardation, without discussion of differential diagnosis, the possibility of learned behavior alone, or other possible explanations for the difficulties. The diagnosis of intermittent explosive disorder required a comment regarding the disproportionality of the individual's response to the circumstance; that was difficult to do in the setting of severe retardation. For that reason the DMID strongly discourages the use of that	

		diagnosis in the setting of severe retardation. For all those reasons, there needed to be a discussion of how intermittent explosive disorder was the appropriate diagnosis, and how the individual met the criteria for that disorder. • Individual # 149 was evaluated in 2013 and diagnosed with Disruptive Disorder NOS. The evaluation itself was excellent, detailed, and accompanied by a well-reasoned case formulation. The psychiatrist pointed out that past diagnoses of psychotic disorder were nonspecific, and that at present no specific symptoms including active psychosis have been noted. The psychiatrist wisely noted that it is possible that the absence of such symptoms could be due to continued treatment with Zyprexa. However, the addition of the non-specific diagnosis of disruptive behavior disorder NOS added little and stood in contrast to the guidance of Appendix B on the use of NOS diagnoses. One viable alternative would have been to leave only the diagnosis of psychotic disorder by history and over time to carefully explore whether antipsychotic treatment could be slowly tapered. <u>Use of NOS Diagnoses</u> NOS diagnoses were present for 44 of 140 (31%) of individuals followed by psychiatry. That was a high number and Per Appendix B guidelines efforts to resolve those diagnoses should continue. Please see comments under Provision J2 <u>Conclusions and Monitoring Team's Compliance Rating</u> The issues that need resolution have not changed. While the overall level of psychiatric evaluations is high, the quality of diagnostic formulations and underlying diagnostic justification is variable. The introduction of the annual updates provides an excellent vehicle to address this matter: The Monitoring Team recommends that for each individual, as the annual update becomes due the psychiatrists should review the current diagnoses and assure that a justification for the current diagnosis or diagnoses is included in either the initial CPE or the update. Of course, should there be changes in the diagnosis in the future, the reasons for the change and the justification should be included in the following annual update. The Facility must strive to complete evaluations for the individuals who do not yet have them. For the reasons noted above, the provision is not yet in compliance.	
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	<u>Reiss Screens for Individuals who lived at the Facility</u> The Facility completed the Reiss Screen process for all individuals who live at the Facility in 2011. Individuals who were followed by psychiatry and who were treated with psychotropic medications were not screened since comprehensive psychiatric evaluations were already required for those individuals. During previous visits the Monitoring Team confirmed that the initial screening was done correctly and that individuals who screened positive received the required comprehensive psychiatric	Noncompliance

	each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	evaluations. <u>Reiss Screens since the Last Visit</u> Between the last visit and 8/23/13 there were fifteen admissions. Individuals #357 and #384 received Reiss Screens and the results were negative. The other 13 individuals who took psychotropic medications were referred to psychiatry, and 13 of 13 (100%) received CPEs. <u>Additional uses of the Reiss Screen</u> Facility procedure is to screen individuals who had either (1) had a change-of-behavioral-status evaluations (as outlined in a protocol for Reiss Screening, revised 08/2013) or (2) had been discharged for six months from psychiatric care. In that case the Reiss Screen was one of several efforts to monitor for continued stability. During the last visit a sample of such evaluations was examined by the Monitoring Team and the results were acceptable. The Monitoring Team did not sample again this visit. <u>Facility Self- Assessment and Self-Rating</u> In the materials provided to the Monitoring Team the Facility did not self- rate for substantial compliance since the provision required that all individuals admitted with a psychiatric diagnosis of prescribed psychotropic medication needed to have a CPE. However, as of August 2013 there were 140 individuals who were followed by psychiatry (132 of whom were medicated). CPEs were in place only for 92 of 140(66%). The Facility also noted that 0 of 4 individuals referred to psychiatry with an elevated Reiss score had the required psychiatric evaluation. Due to these difficulties the Facility did not self-assess for substantial compliance for this visit. <u>Monitoring Team's Compliance Rating</u> The Facility's use of Reiss Screen was appropriate. The Facility did not provide Reiss Screens to assess the need for psychiatric treatment for individuals who already received such treatment. However, those individuals did need to have psychiatric evaluations and not all have received one. As above, all the new admissions to the Facility who took psychotropic medications received CPEs. However, there were individuals who lived at the Facility who had received neither a Reiss Screen nor a psychiatric evaluation. Overall, only 66% of individuals who needed psychiatric evaluations had them. That was unchanged from the percentage of required evaluations that were in place at the time of the last visit 93 of 140 (66%). The need to complete required psychiatric evaluations is the only matter that prevents this provision from obtaining a rating of substantial compliance.	
J8	Commencing within six months of	Provision J8, through its focus on combined assessment and case formulation, was the	Noncompliance

	the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	place where the Monitoring Team focused on integrated care throughout the Facility process. <u>Combined Behavioral Case Formulations</u> Combined case formulations, typically between psychology and psychiatry, should assure that a common understanding is in place regarding which aspects of the individual's clinical presentation are best explained as learned behaviors and which reflect psychopathology. Formulations were typically one or two paragraphs long, they referred to the DSM diagnosis, and each of the aspects of the individual's behaviors were listed as best accounted for by psychological difficulties, psychiatric difficulties or both. The Monitoring Team reviewed two sets of records to assess the adequacy of the combined case formulations. First the Monitoring Team reviewed the BAIP/PSP for Individuals #255, #42, and #417. These were individuals who were reviewed on 10/8/13 at the PBSC meeting. The combined formulations for each of the three were acceptable. The Monitoring Team also reviewed the PBSP/BAIP/PSP for case formulations for each of the individuals in Sample J1. These were located for nine of 10 (90%) of the records. The exception was Individual #149 who had an older plan that appeared not to have been converted to the current format. The Monitoring Team was invited by the Facility to participate after the 10/08/13 PBSC meeting in an informal discussion on the quality of the case formulations, focusing on Individual #255 who had been presented at the meeting. That discussion focused exclusively on the matter of differentiation of function (typically between psychological and psychiatric elements). The Monitoring Team reviewed nine PBSCs from Sample J1 and three BAIPs reviewed at the PBSC on 10/08. In 12 of 12 (100%) of the records that were reviewed there was an adequate discussion of differentiation of function between learned behavior and psychopathology. On the broader matter of the overall case formulations, the Monitoring Team clarified that at times what was presented was a case summary rather than a case formulation. Again, there was room for improvement but all 12 records reviewed were deemed adequate. <u>Combined Care at PTRs</u> This was reviewed under Provisions J3 and J11. The team process and collaboration between the behavioral disciplines remained strong at the key function of the PTR. <u>Integrated care at Morning Medical Meetings</u> The Monitoring Team attended the meeting on 10-08-13. The discussion was balanced between the clinical disciplines. Discussion during the meeting about an individual who had PNMT issues and how they related to medical and behavioral concerns was a good	

		example of integrated care. In the previous report the Monitoring Team had indicated that further progress was needed in several areas and these were revisited: • Coordination of behavioral and pharmacological care: It was positive that medication treatment plans have now been put in place and that BDS sheets were being developed for new treatments. Good progress has been made but further progress is needed (see discussion for Provision J13). • Integrated care at the level of the ISP: The Facility clarified that improvement in that area has been a major focus for psychiatry, and the vehicle for improving psychiatric information improvement in that area was the psychiatric contribution to the IRRF reviews. Improvements were noted but adequate IRRFs were present for only four of 10 (40%) of individuals in Sample J1. • Integrated care to minimize the need for medical restraint/pretreatment sedation: • As reported under Provision J4, progress in that area lagged behind others. Nonetheless, a good process appeared to be in place for the development of the plans to reduce the need for medical restraints, a topic which necessarily involved the behavioral healthcare team, medical and dental teams. <u>Monitoring Team's Compliance Rating</u> Processes for improving integrated care were ongoing and the Facility was encouraged to continue to focus on the areas listed above. Progress has been made, but the Facility was not in full compliance at this time due to the areas of need listed above.	
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	Provision J9 required that three things were needed before a proposed PBSP (at the Facility, now a BAIP or PSP) could be implemented. 1. <u>The IDT and psychiatrist should determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition:</u> Information on new psychiatric treatments was presented in an ISPA, and the Monitoring Team was informed that the ISPA was the place where the determination of least intrusive and most positive interventions was documented. To assess whether that was done the Monitoring Team reviewed Sample J2 (new medications) and examined the ISPA for each proposed medication. ISPAs were provided for 15 of 16 (94%) of the medications in Sample J2 and the ISPA shell contained a section on "History, previous interventions and results." The guidelines for that section were for IDTs to consider (1) what interventions had been tried before the use of a new psychoactive medication was considered and (2) what were the results of the previous interventions. In some cases the ISPA addressed the issue of less intrusive and positive treatments directly. For example, the ISPA for	Noncompliance

	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.	Individual #42 stated "The Individual has a positive behavioral support plan that targets aggression and destruction. The team also provided (the Individual) with a swing and has ordered a shredder which provides her with an activity that she enjoys." For Individual #341 the ISPA stated that "interventions that have been used before the use of a new psychotropic medication were considered are attempts that have been made to manipulate the environment by allowing the client to transition at a later time. Additionally during transition times (the individual) had been provided an escort to get him off the bus and help him transition (to the next location)." In other cases there was simply a statement such as "Behavior plan is in place" Overall, in 10 of 16 (63%) proposed treatments, there was some mention of behavioral interventions. In six of 16 (37%), there was no mention of behavioral interventions. A summary of the IDT analysis of previous interventions was presented to the HRC for review in 16 of 16 (100%) cases. In many cases the summary referred only to verbal redirection and interpositioning as the previous treatments. A brief but individualized statement would have been better than the language that was used, which seemed to be standardized . 2. <u>The PST and psychiatrist should determine whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone</u>: ISPAs contained no item that directly addressed that issue. In many cases the ISPA indicated that a PBSP was in place and in the context of a request for a new medication one could infer that both the new medication and the existing behavioral treatments were needed. But even that referred to what was in place or proposed, and that did not address the issue of the kind of treatment that would best serve the individual. Overall, the question was addressed adequately in only two of sixteen (13%) of the treatment proposals in Sample J2. 3. <u>For individuals who take 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> For all individuals, the treatments in question were addressed in PBSP and ISP documents (see discussion under Provision J3). During the visit the Monitoring Team met with the Facility and reviewed the requirements for this provision. The Monitoring Team commented that the Facility procedure of conducting a team meeting to review proposed treatments was a positive practice and the Facility confirmed its intent to address the requirements of Provision J9 in that setting. As described above, that was not done for many cases in Sample J2. <u>Monitoring Team's Compliance Rating</u>	

		Additional attention is needed to ISPA discussion and documentation.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Per the language of the provision, before non-emergency administration of psychotropic medication, there needed to be a discussion about the risks associated with providing treatment vs. the risks of not providing the treatment. <u>Facility Process for Risk vs. Risk Analysis</u> As described under Provisions J13 and J14, the process of discussion, documentation, and review of the risks of medication treatment, in comparison to the risk of not providing the treatment, included an IDT meeting to review the new medication discussion (documented as an ISPA), psychiatrist preparation and discussion with the legally authorized representative (LAR) of a medication treatment plan and informed consent document, and a review of the results with the Facility oversight committees including HRC. Risk vs. risk analyses/reviews took place at each of those steps, as follows: • The ISPA meeting to review the new medication was guided by the ISPA shell described under Provision J9. It included eight different areas of review. One of those was overall risk review, and in one element within that section the IDT was explicitly guided to discuss the risks associated with providing the treatment vs. the risks of not providing the treatment. • The PMTP contained a list of the common side effects of the proposed medication and check-off boxes indicating whether the risks of not treating the psychiatric condition are greater than the possible risks of medication treatment. • The informed consent document specified both risks of treatment and risks of non-treatment. • The revised HRC review form included a risk vs. risk analysis for psychoactive medication. Since the last visit revisions for clarity were made in several of the documents that were responsive to questions/concerns raised by the Monitoring Team: The PMTP was revised so that it was appropriate for both new medications and annual renewals (see discussion under Provision J14), the informed consent document was revised to include risks of treatment and non treatment, and the HRC review form was modified to differentiate between the risks of the behavior plan and the risks of the medication treatment. <u>ISPA Determinations</u> The Monitoring Team reviewed the 16 medication treatments in Sample J2. ISPA reviews for the new medications were received for 15 of 16 (94%) of the medications. In each case the ISPA that documented determination by the IDT.	Substantial Compliance

		The quality of the reviews IDT/ISPA reviews for risk varied. . The form itself simply states "Risk Assessment" and that was interpreted variably by different IDTs. In some cases, the level of risk was addressed in the manner one would for the IRRF (for example, see Individual #167, for Ambien). In other cases there was simply a repetition of side effect information (for example, see Individual #144, for clozapine). Other cases contained extremely helpful discussions of risk vs. risk that clarified much about the plans for medicine in a manner the complemented the overall psychiatric treatment plan. For example: • Individual #52 had taken topiramate for neurological indications but it was no longer needed for that purpose. The psychiatrist decided that it would continue to be helpful for psychiatric purposes and the ISPA for its psychiatric use was convened. The IDT commented: *"Topiramate can cause appetite suppression. (The Individual) should be treated with a low dose of topiramate because he has a history of being below his recommended weight range. He gained weight when the topiramate was decreased from 200 mg per day to 100 mg per day…. (The individual) since topiramate was reduced he gained weight and is now within his weight range. The team agrees that the risk of (the Individual) being injured in an episode of aggression is greater that the risk of taking topiramate. (The individual) had fewer episodes of aggression when he was taking a higher dose of topiramate that he takes now.* In these comments the IDT clarified that topiramate had both benefits and drawbacks, that the IDT had considered details like risk and benefits at the proposed dose range and had come to its conclusion about risk vs. risk with knowledge of both the individual and the medication. • Individual #243 took Risperdal, but the dose of that medication was limited by side effects and Zyprexa was proposed to replace it. The IDT wrote "*(The individual) has a history of improved functioning on antipsychotic medication however; she had adverse side effects (tremor on Risperidone 2 mg.) The current dose of 1 mg per day is not effective. Team has already tried increasing dose for her other medications with little improvement. (The individual is at risk for health complications, if she loses any more weight. The risk of taking Zyprexa is no greater than the risk of taking Risperidone. Zyprexa has less risk of causing tremor, so (the individual) may be able to tolerate a dose which is more effective than Risperidone in addressing her symptoms). If she is calmer, she may be more compliant in taking her medication and eating her meals.* Here too, the statements about relevant risk were individualized and informed. In each of the cases reviewed the IDT made the required determinations about risk of the illness and the proposed treatment. Those determinations were properly included in the materials provided to the HRC for review (see below). Nonetheless there was room for improvement in the ISPA documentation of the IDT's discussion about risk. In the	

		sample reviewed an adequate discussion of risk vs. risk information was provided in on 11 of 15 (73%) of the ISPAs. The Monitoring Team encourages the Facility to review with IDTs the guidelines for risk vs. risk review at the ISPA level. <u>PMTP data</u> The Monitoring Team reviewed the 16 medication treatments in Sample J2. For each of the 16 medications (100%) a PMTP was located and each contained a review of risk vs. risk assessment. The PMTP was prepared by the psychiatrist and reviewed with the IDT psychologist, QIDP, PCP and RN case manager, often at the PTR. PMTPs were completed and dated in all cases. Review and signature of the PMTP by all required participants reflected their meaningful participation in the process of review of new medications. <u>Consent for Treatment Data</u> The Monitoring Team reviewed the 16 medication treatments in Sample J2. Sixteen of 16 (100%) of the consents for treatment included the review for risk vs. risk assessment. The section on risk vs. risk was competed in all cases. <u>HRC Review of Medication</u> The Monitoring Team reviewed the 16 medication treatments in Sample J2. HRC review of medication was provided in all cases. The current format contained three items, described here with information from the request for zolpidem for Individual #167. There were three items on the HRC review that pertained to the requirements of this provision. • Risk of having a PBSP and/or psychoactive medication: For Individual #167 the response read "potential side effects of medication (zolpidem) dizziness, lightheadedness, headache, upset stomach, diarrhea, and dry mouth. " • Risk of not having a PBSP and/or not taking psychoactive medication for Individual #167 the response read: "The individual's psychiatric symptoms and challenging behaviors may increase that could lead to injuries to her or others." • Risk vs. Risk analysis: "The risk of the Individual's challenging behaviors and risk of injury related to the psychiatric symptoms outweighs the possible side effects associated the administration of psychotropic medications." The three items were completed in a satisfactory manner for all 16 (100%) proposed medications. In the past, HRC reviews did not clearly differentiate between risks associated with the proposed medication vs. the overall treatment program, were not specific about which medication was being reviewed, and did not contain the needed analysis. These were already remedied during the current review. The form itself was improved and now clearly stated the needed information and the forms were properly completed in all cases.	

		The matter of side effect information was addressed optimally: In the course of presentation of information about possible side effects, the individual's guardian was typically provided with two sources of information. First, there was a description provided by the pharmacy that contained exhaustive information about possible side effects. In addition, reflecting best practices, the psychiatrist highlighted information to the Legally Authorized Representative (LAR) about specific side effects that might be relevant to the individual, perhaps due to the greater overall frequency of those side effects, or perhaps due to factors that were specific to that individual, such as particular medical or psychiatric problems, vulnerabilities the individual might have, or past experience with similar medications. It was the shorter list of most important side effects that was cited in the PMTP and was repeated in the HRC review. <u>Alternative treatments:</u> In the past the Monitoring Team had encouraged the Facility to provide more detailed information about alternatives to the proposed treatment. The Facility has been responsive to those concerns and has placed the relevant information in the medication consent form. The psychiatrist presents that information to the Legally Authorized Representative (LAR), and both the psychiatrist and LAR sign that document. The revised form for informed consent contained entries for treatment alternatives and for any recommended adjunctive treatments (such as environmental supports, psychological therapies, PBSP and others). The relevant sections on treatment alternatives were completed in 16 of 16 (100%) of the medication consents reviewed and all consents were properly signed/dated by the psychiatrist and by the LAR. (See further discussion on consent under Provision J14) <u>Conclusions</u> There has been marked improvement in the way the Facility provided information about risk vs. risk discussions and treatment alternatives. There is now clarity and structure in the Facility process: The required elements of the Provision were discussed by the IDT at the ISPA meeting, were included in the PMTP and were presented to the LAR by the psychiatrist as part of the consent process. HRC reviews were assisted by well prepared summaries that were specific to the individual, to his/her circumstances and the medication in question. While there was room for improvement in some of the details – for example in the ISPA discussion of risk - the system put in place was robust and had already assured that risk was addressed adequately at other places in the process as well. <u>Monitoring Team's Compliance Rating</u> With the improvements put in place the requirements of the provision have now been met and the Facility is now in compliance with the provision requirements.	

J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	<u>Process in Place for Facility-level Review</u> The PMOC continued to meet on a monthly basis, and it was the principal venue for Facility- wide review of medication practices and polypharmacy. Participation in the POMC included psychiatry, medicine, nursing, psychology, and quality assurance. The Facility-level review augmented reviews of polypharmacy that took place at the level of the IDT, where polypharmacy was reviewed in many venues. For example, individuals were reviewed for polypharmacy at PTRs (see discussion for provision J3, J9, J10), polypharmacy was part of the discussion about proposed new medications (see Provisions J9, J10, J13 and J14), and polypharmacy was also the focus of IRRF discussions including at the annual ISP meetings (see discussion under Provision J8). <u>Review of Polypharmacy Data</u> The Monitoring Team attended the POMC meeting on 10-08-13 and data on 134 individuals who received psychotropic medication in September, 2013 were reviewed. Please note that elsewhere in this report 132 individuals are cited. That is because that figure was correct when the Facility Self Assessment and related documents presented to the Monitoring Team were prepared. The overall rate of psychotropic medication treatment was 134 of 288 individuals who lived at the Facility (46%). Fifteen of the 134 (11%) had intraclass polypharmacy, and 44 of 134 (33%) had interclass polypharmacy. A third statistic calculated was the total number of individuals who had some form of polypharmacy. That statistic was cited in Facility reports as the psychiatry polypharmacy rate; at the time of the visit the psychiatry polypharmacy rate was 46 of 134 (34%) individuals. The Monitoring Team reviewed psychiatry polypharmacy rates since 2011. A graph of psychiatry polypharmacy rates showed a gradual and sustained decline from 42% in August, 2011 to the current rate of 34%. <u>Individual Justifications for Polypharmacy</u> The Monitoring Team reviewed those polypharmacy justification sections of the PMR for the 28 individuals who were deemed by the Facility as having "justified polypharmacy." The list included (1) individuals for whom the psychiatrist appeared to have concluded that current polypharmacy should be maintained due to that individual's current and past response to medications, (2) individuals for whom only a pharmacological explanation for the polypharmacy was offered (such as use of three medications from different pharmacological classes), and (3) individuals who were assessed as needing polypharmacy now since they were not stable, were newly admitted, or had other circumstances , but for whom medication reductions might be possible in the future. If the Facility would like to prepare a list of individuals from the first category and provide the data that supported the determination that polypharmacy should not be challenged in those individuals, the Monitoring Team will available to review each case during the next visit and provide feedback regarding whether the presented data justified the conclusion.	Noncompliance

		Conclusion The Facility continued to make efforts to ensure that medications that were not clinically justified were eliminated. Over the past two years, the overall rate of polypharmacy has gradually declined from 42% to 34%. Efforts to reduce polypharmacy must necessarily be based on the assessment of each individual's needs, and that is what the Facility is doing. At the same time, the psychiatry polypharmacy rate provided a broad measure of medication practices, and that rate remained high. The need to continue to reduce the rates of polypharmacy was the focus of detailed discussions with the Facility and the efforts to do so will be aided by planned monthly reviews of the status of efforts to reduce polypharmacy in individuals assessed to be in need for such reductions. Progress continues but work remains to be done.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	At the Facility MOSES evaluations were required at a minimum of every six months, and DISCUS evaluations were required (for individuals who took medications that can cause tardive dyskinesia) at a minimum of every three months. Facility screening for dyskinesia included all individuals who took Reglan, a medication prescribed for non-psychiatric indications that can cause dyskinesia. DADS Policy 7.3 (effective 05/01/2013) for psychiatry stated that MOSES and DISCUS side effect screens would be provided following a change in medication dose, as determined clinically necessary by the psychiatrist. The policy also clarified that side effect screens should be reviewed by the physician within 7 working days. Physicians are required by policy to review and sign the side effect screening forms. Completion of MOSES and DISCUS Screens for Individuals Taking Psychotropic Medications Since the last visit the Facility had has transitioned to tracking MOSES and DISCUS evaluations via the AVATAR system. Review of a spreadsheet of MOSES and DISCUS administrations showed that all individuals who required DISCUS examination received them and 16 of 132 (12%) individuals who took psychotropic medication had additional screenings due to changes in medication dosing. For the MOSES examinations individuals received the required screening and 15 of 132 (11%) had additional administrations due to changes in medication dose. Completion of Side Effect Screens for Individuals taking Reglan The Facility informed the Monitoring Team that nine of the 288 (3%) individuals who lived at the Facility took Reglan. The database showed that those individuals received the required screenings. The Monitoring Team had examined the actual administrations during a previous visit and did not do so during the current visit. Quality of Completion of Side Effect Rating Scales	Substantial Compliance

		The Monitoring Team next reviewed the records of the 10 individuals in Sample J1. All received the required MOSES and DISCUS administered with the required frequencies. None received additional screenings. That was not surprising since the sample consisted of individuals who were clinically stable on their medication regimens Of the 10 administrations of the MOSES, six of 10 (60%) were reviewed in a timely manner. For the DISCUS examinations 14 of 20 (70%) were reviewed in a timely manner. The Facility informed that Monitoring Team of both the change and the efforts. In all cases the side effect screens were reviewed by the physician. The Facility informed the Monitoring Team that efforts were underway to assure timely reviews by physicians. To maintain compliance, the Facility must ensure this was only a temporary lack of timeliness in the context of ongoing compliance. The Monitoring Team noted that for many of the administrations the new AVATAR form was used. The printouts of that form did not include the physician comment sections for the two side effect screens. Physicians did sign and date the printouts, and often included comments about the nurse's observations. However, that could not substitute for completion of the sections of the examination intended for the physician. The Monitoring Team inquired about the reasons for the omission and learned that in the future the physician sections will be included in the AVATAR administration, but that physicians could not yet access the AVATAR system to be able to complete the forms. The Facility indicated that it would expedite that process. To maintain substantial compliance at the next compliance visit, this will need to be resolved soon enough to show a continuing pattern of completion of the physician sections. <u>PTR/ QDRR review of side effect screens</u> During the visit there were no PTR reviews and the Monitoring Team could not observe current process. However, review of the PTR and QDRR documents from the individual in Sample J1 showed that there was good attention to results of the side effect screens. <u>Training for Side Effect Rating Scales</u> During the visit the Monitoring Team met with members of the nursing staff to review the training provided to nurses on the administration of the side effect rating scales. There were no changes since the last visit. The Facility provided a printout of training dates and participant names that showed that that since July 1, 2013, 100% of the nurses completing nursing orientation had reviewed the MOSES/DISCUS videos. No information was received about annual re-training for the side effects scales by the nurse case managers who had completed the ratings. <u>Monitoring Team's Compliance Rating</u> At the last visit the Monitoring Team found the Facility in compliance with the requirements of this provision. That cannot be sustained in the absence of completion of	

		the required physician sections of MOSES and DISCUS screens. Since the Monitoring Team was assured that physician access to the AVATAR system will be expedited and that will allow resumption of their participation in the rating process, no change will be made for now in the finding of substantial compliance. Rapid resolution of the matter is needed, however. Similarly, physician review must be completed in a timely manner, in order to maintain the status of substantial compliance.	
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.	The Facility has continued to use and has improved the Psychiatric Medication Treatment Plan (PTMP) with revised formatting (08/30/13). The current version added treatment goals to the matrix of information about medications. The Monitoring Team reviewed the medication plans for the 16 medications in Sample J2. A PMTP was completed for 16 of 16 (100%) of the medications. The following sections of the PMTP related to the requirements of the provision: <u>Clinically justifiable diagnosis or specific behavioral pharmacological hypothesis</u>: The PMTP has a place for (1) the Axis I diagnosis, (2) the treatment rationale and (3) focus of treatment (psychiatric, behavioral or both). These were present for all medications. As pointed out elsewhere in this report (see Provision J6) not all diagnoses were clinically justified. In the setting of the PMTP an additional question is whether there is a reasonable linkage between the diagnosis and the proposed medication. There needs to be one and going forward, the format adapted by the Facility will allow transparent examination of whether the linkage is present. <u>Timeline for the therapeutic effects of the medication to occur:</u> The PMTP has an entry for "expected drug response" and the sample provided by the Facility listed the type of medication and the expected time for therapeutic effects to be achieved. This was completed for all medications. <u>By whom, when and how the monitoring (for efficacy) will occur:</u> The PMTP form clarified that "An evaluation of treatment efficacy will be conducted to determine if the medication dose should remain the same or be increased or decreased. Treatment response will be evaluated during PTRs or as clinically warranted." That was included in the formatting of the PMTP. <u>How often the monitoring will occur (as often as necessary based on the individual's current status and/or changing needs, but no less often than quarterly</u>.) The language cited for the previous item applies here, too and was included in the PMTP for each medication. <u>Objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy:</u>	Noncompliance

		The PMTP has an entry for "Treatment Efficacy Scale – Data or Scale." Rating scales were named. The Facility indicated that if a rating scale will be used, it will be named. The Facility clarified that "data" meant that an operationally defined behavior(s) that the psychiatrist and IDT have decided to use as a marker for treatment response will be the agreed upon measure for treatment efficacy. For eight of 16 of the medications (50%) the IDT was guided by operationally defined data, and for four of 16 medications (25%) rating scales were selected. The selected scale for one medication was the PSRA scale, for another it was Connor's scales, and the PMTPs for two medications stated only "rating scale." For four of 16 (25%) of the medications a combination of both a scale and data was selected; in three of those cases the scale was the Bipolar Disorder Symptom Scale (BDSS) and for one it was the Anxiety, Depression and Mood Scale (ADAMS). The selection of behaviors to be monitored and scales appeared to be appropriate, with the caveat that when nonspecific diagnoses were used (for example intermittent explosive disorder) the resulting reliance on aggressive behavior and self-injury as data was unavoidable but contributed little. That said, the underlying difficulty was not the data collection per se, but rather the lack of a better diagnosis. During the visit the Monitoring Team reviewed the BDSs for each of the sixteen medications. It was readily apparent that considerable progress had been made, and that work involved interdisciplinary teamwork between psychology and psychiatry. It was clear that a significant effort was underway to provide psychiatry with the needed support. For example, not only were rating scales in use, but the ratings obtained were often graphed for use during PTRs. It was of course not surprising that many issues related to data display for psychiatry were not yet resolved. For example, in three of sixteen BDSs (18%) data on medications were not included. In others, behavioral data was displayed, but not the data designated by the treatment plan for medication. There was also no consistency to the formatting of the presentation. Although cases and displays will necessarily vary, the absence of an agreed upon norm will result in unnecessary distraction for the psychiatrist during a busy meeting, as she has to struggle to sort out what exactly is displayed. Similarly, there were cases where graphs that needed to be compared were unnecessarily displayed on different sheets of paper, did not share the same time scale, were not scaled appropriately and so forth. There were also issues with excessive presentation of raw data that could not be reasonably processed in the midst of a PTR meeting; in those cases summary data was more appropriate. In other cases, data was presented that was only marginally related to the medication tracking and were therefore distracting. With the above in mind, a meeting was held during the visit to discuss the matter of BDS data presentation for psychiatry. During the meeting the Monitoring Team encouraged the Facility to develop a reasonably consistent format of presentation that could be viewed in real time during the PTR, and did not require participants to study the materials ahead of the meeting. At minimum the presentation should include technically	

		adequate graphs of data deemed appropriate for tracking, (or perhaps one graph for operationally defined data and another for rating scales) and a graphic display of medications over time. Such a focus would allow direct comparison of medication and dosing in comparison to the agreed upon measure of efficacy. Such graphing could serve to initiate discussion between IDT members as to medication efficacy, so that the subsequent decision making could be informed by that information, along with other sources of information like the psychiatrist's mental status exam and direct reports from DSS participants. The meeting touched upon some technical specifics such as what to do when different medication plans required different data sources (sometimes more than one set of graphs was needed). The meeting also touched on the need for quality control regarding rating scale administration and scoring, and the need to choose appropriate rating scales for the selected symptoms. <u>Monitoring Team's Compliance Rating</u> The implementation of PMTPs and BDS guided data represented significant progress. The system used has matured rapidly and it will help psychiatrists make needed determinations about medication efficacy, assisted by results of agreed upon outcome tracking. Progress toward substantial compliance will depend largely on (1) successful completion of the deployment of the system for efficacy tracking and (2) the demonstration by psychiatrists that their decision making had included consideration of the relevant behavioral data. Although progress has been made, the provision is not yet in substantial compliance.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	<u>Facility Policy</u> DADS Policy and Procedure 007.02 Psychiatry Services (08/30/11) detailed that "State Centers must obtain informed consent (except in the case of emergency) prior to administering psychotropic medications (or other restrictive procedures)." The Policy also stated that State Centers must provide education about medication when appropriate to individuals, their families, and LARs according to accepted guidelines." <u>Facility Progress on the Provision</u> Since the last review there have been a number of changes which improved the informed consent process and documentation, including changes to the PMTP (effective 08/30/13) and the Consent for use of Psychotropic Medication for Behavior Support (revised 08/30/2013). These have been part of the overall improvement process and in response to concerns/comments made by the Monitoring Team. For convenience the changes/improvements are reviewed topic by topic. • Treatment alternatives: In previous reports the Monitoring Team commented that a key component of meaningful consent was an open discussion with the LAR about viable treatment alternatives, in some cases including no treatment. On this matter Provisions J10 and J14 are closely linked. As discussed in detail	Substantial Compliance

		under Provision J10, a full exploration on options for treatment is now in place. That includes full discussion of that topic in ISPA meetings for new medications and inclusion of relevant information in the PMTP. In addition, the Facility has modified the form for consent for new medication. That document is sent to the LAR and is the basis of discussion for the proposed medication between the psychiatrist and LAR. The revised consent form presents a variety of options such as (a) different medications, (b) additional supports such as counseling, (c) a combination of medication and non medication treatments and (d) no medication treatment. • Renewal of existing medications: The process for annual review of ongoing medications has been revisited and revised by the Facility. PMTPs are now generated for each individual at the time of the annual review of treatment, and the information on the PMTPs is updated to reflect the accumulated experience of the individual with the medication. PMTPs were presented/reviewed at PBSC by psychiatry, to assure integration of the psychiatric information with the overall behavioral treatment program. (BAIP, PSP or other). • Off- label use of medication: Information about the labeled use of the medication is included in the PMTP that is forwarded to the LAR along with the consent form. That assures that the discussion about consent is based on full information about the medicine and its use. • Preparation of the consent and communication with the LAR by the psychiatrist: The Monitoring Team has emphasized the need for direct and informed communication between the LAR and psychiatrist. The psychiatrist is the person who presents information about the medication and its use to the LAR, for both new and annually reviewed medication. Information on the PMTP for medication renewals is informed by the actual experience of the individual with that medication, which is different than the textbook information about the medication that might be the basis for a conversation about the medication at the outset of treatment. • Presentation of information to HRC: HRC review is an integral part of the consent process and the HRC must have access to the information that has guided the psychiatrist's communication with the LAR. The improved use of the HRC review form is presented under Provision J10. <u>The Process Now in Place for Consent</u> For new medications, the ISP met for an ISPA meeting on new medications, as described under Provisions J9 and J10. The psychiatrist then prepared a PMTP and medication consent form, and those materials were sent to the LAR for review. The psychiatrist then reviewed those materials with the LAR for the LAR's approval and signature. When verbal (telephonic) approval was needed, the LAR's verbal approval to the psychiatrist was witnessed by an RN. The PMTP and consent for both new medication and for annual review of ongoing medications were reviewed by PBSC and HRC. Presentation of	

		information to the HRC about the medication was by a member of the psychiatry department (often by the psychiatry assistant) and when necessary, by a psychiatrist. Monitoring Team's Review of New Medications The Monitoring Team reviewed the informed consent form for the sixteen medications in Sample J2. All sections were completed and forms were signed by LARs and the psychiatrists in 16 of 16 (100%) cases. HRC review was appropriate and complete in 16 of 16 (100%) cases. Monitoring Team Review of Annual Medication Renewal The Monitoring Team reviewed the informed consent form for 17 medications for the 10 individuals in Sample J1. Consent forms were provided for nine of the 10 (90%) individuals (the exception was Individual #187). HRC reviews were provided for eight of 10 (80%) individuals (exceptions were Individuals #305 and #187). The Monitoring Team notes that a cover sheet provided by the Facility for materials related to Individual #305 indicated that HRC review was provided; during the visit the Monitoring Team reviewed with the Facility that there had been a recent transition from use of a single two sided form for PBSC and HRC reviews to two separate one sided forms. The Monitoring Team did receive the PBSC review for Individual #305 and it is possible that an older two sided form was used and one side was not copied. Conclusion and Monitoring Team's Compliance Rating A robust system for informed consent was in place. The consent was based on well developed medication treatment plans that the psychiatrist then reviewed with the LAR along with the consent itself. In addition, the Facility HRC was provided with information that assured that the relevant information that pertained to risk and benefits was addressed and provided to the LAR. By developing and implementing a system that provided these elements, the Facility has provided what is required by the SA and has come into compliance with SA requirements.	
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.	Facility Policy: DADS Psychiatry Policy 007.3 (05-091/01 2013) addressed the topic of integrated care between psychiatry and neurology as follows: "W*hen medications are prescribed to treat both seizures and a mental health disorder, the neurologist and psychiatrist must coordinate the use of the medications, through the IDT process.* Review of Individuals Supported by Psychiatry and Neurology The Monitoring Team reviewed the care of five individuals who took seizure medication for both neurological and psychiatric indications. They were Individuals #185, #332, #377, #411, and #588. Materials reviewed included both psychiatry and neurology clinic notes. The results were: • Individual #332: Neurology clinic notes from November 2012 show that	Substantial Compliance

		Tegretol was listed as a dual purpose medication and the drug level was of 8.5 (therapeutic). Dr. Chacko attended the clinic for psychiatry along with the PCP, Dr. Austin. Discussion at the PTR on 06/13/13 included review of the neurological input and a comment that any changes in the dosing of Tegretol would have to include the neurologist. In the PTR of 08/22/13 Dr Morgan also explored the need for psychiatric use of Tegretol for autism, now that the diagnosis was being reexamined. The coordination of care between neurology, psychiatry, and medicine was good. • Individual # 377; the PTR notes from 06-25-13 show that Depakote was linked to autism and showed an indication of aggression and seizures. However, per neurology notes from 2011 it appeared that he had not had any seizures since 2002 and the neurologist suggested at that time that the medication was probably not needed for neurology. If the PTR documentation for the use of Depakote as a dual purpose medication was correct, perhaps that designation should be reconsidered. • Individual #185 was reviewed in neurology clinic in June, July and August 2013 related to seizure management with changes in Topamax (now discontinued) and Lamictal. Tegretol continued to be used for seizure and for psychiatric indications. A psychiatric progress note from July noted the possible association of dizziness with the Topamax. The difficulties with both seizure management and with somatic complaints persist but there appeared to be good communication between psychiatry, neurology, and medicine to resolve these issues. • Individual #588 was last seen in neurology clinic in December of 2012. Dr. Morgan attended that meeting that noted use of three medications (apparently Dilantin, Depakote and zonisamide as well VNS) for seizures. The PTRs of May and July 2013 reviewed the use of Depakote as a dual purpose medication. The client continued to be seen quarterly for PTRs. and the PTR notes correctly listed which medicines for seizure control alone and which were designated as dual purpose (Depakote). • Individual #411: The most recent neurology clinic note from December 2012 documented the individual's seizure free status and the use of Depakote as a dual purpose medicine. The PTR notes (most recently from July 2013) correctly reported the dual purpose designation of Depakote. <u>Monitoring Team's Compliance Rating</u> Communication between neurologist and psychiatrist remained good. The Monitoring Team learned during the visit that clinical pharmacy support will be extended to the neurology clinic and that will further enhance integrated care in that setting. The provision remains in substantial compliance.	

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:** 1. BSSLC Self-Assessment (9/23/2013) 2. BSSLC Action Plan (9/19/2013) 3. BSSLC October 2013 Presentation notes 4. Minutes for the Positive Behavior Support Committee (4/15/2013 – 9/3/2013) 5. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Programs (SAPs), Positive Behavior Support Plans (PBSPs), Structural and Functional assessments (SFAs), Behavior Assessment and Intervention Plans (BAIPs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the BSSLC Self-Assessment and Action Plan. The following individuals were included in the review: Individuals #27, #31, #35, #51, #52, #58, #75, #112, #133, #141, #158, #163, #165, #167, #187, #206, #243, #249, #255, #276, #288, #299, #304, #314, #349, #367, #370, #390, #408, #425, #471, #484, #490, #496, #514, #517, #536, #539, #582, and #590. 6. A subset of the individuals above was included in the review of treatment data collection and monitoring. The individuals in this subset included Individuals #27, #35, #51, #52, #133, #167, #255, #299, #349, #390, #408, #425, #484, #490, and #590. 7. A subset of the individuals above was included in the review of intellectual, adaptive and behavior assessments. This subset included Individuals #27, #35, #51, #52, #133, #167, #255, #299, #349, #390, #408, #425, #484, #490, and #590. 8. A subset of the individuals above was included in the review of newly admitted individuals. The individuals in this subset included Individuals #215, #231, #240, #248, #251, #263, #357, #384, #439, and #580. 9. A subset of the individuals above was included in the review of non-PBSP interventions. The individuals in this subset included the following. • Five individuals with counseling plans: Individuals #206, #243, #360, #539, and #582 • Five individuals with Psychiatric Support Plans: Individuals #158, #187, #288, #517, and #536 • Three individuals with Environmental Support Plans: Individuals #35, #141, and #165 10. A subset of the individuals above was included in the review of data presentation and integrity. The individuals in this subset included Individuals #27, #35, #51, #52, #133, #167, #255, #299, #349, #390, #408, #425, #484, #490, and #590 **People Interviewed:** 1. Terry Blackmon, PhD – Chief Psychologist 2. Donna Bradley·Schrick, MA, LPC, BCBA – Behavior Analyst I 3. Sara Bohl, MA, BCBA – Behavior Analyst I 4. Fara Goodwyn, MEd., BCBA – Behavior Analyst I

	5. Jana Lehrman, MA, BCBA – Associate Psychologist V 6. Victoria Morgan, MD – Psychiatrist 7. Kim Littleton – ADOP 8. Cheryl Powell – Human Rights Committee Chair 9. Direct Support Professionals: Approximately 20 staff were interviewed in Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences. **Meetings Attended/Observations:** 1. Positive Behavior Support Committee (PBSC) 2. Behavior Services/BCBA Meeting 3. Human Rights Committee (HRC) 4. Restraint Reduction Committee 5. Observations were conducted in Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. At the time of the site visit, BSSLC reported in the Self-Assessment that Provisions K.2, K.3, and K.11 were in substantial compliance with the Settlement Agreement. The Monitoring Team was in agreement with the Facility concerning all three Provisions. For Section K, in conducting its self-assessment, the following was noted. ▪ The Facility did not typically indicate specific tools used for the review of Section K. The only formal tool noted was the FBA/PBSP Evaluation Tool ▪ The Facility did use a variety of relevant data sources. These data sources included the departmental tracking databases for staff progress toward board certification, PBSC approvals, external peer review, treatment integrity, inter-observer agreement, Progress Note reviews, BAIP readability grade levels, intellectual assessment, and adaptive skill assessment. Although the Facility did not frequently describe the specific procedures used when compiling ratings and using these data sources, the outcome data achieved was often equal to that reviewed by the Monitoring Team. ▪ At times, the Facility presented information in meaningful ways. For example, the Facility described in detail the process for rating BAIPs submitted for PBSC review. In other areas, the information provided by the Facility was less useful. For example, although the Facility reported that psychological assessments were reviewed for accuracy, the measures reported consisted only of whether assessments were completed and if the assessments were current. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The majority of components of the Action Plan were described as being in process or completed. Although these statements were accurate, it was important to note that for the most part they

	addressed quantitative rather than qualitative goals. For example, one item in the Action Plan was, "Review of treatment integrity on a monthly basis by the assigned BCBA." The conducting of such a review would likely be important. Without a qualitative component, however, it would be difficult to determine if the goal was completed in a manner that would assist with attaining substantial compliance with the Settlement Agreement. It is recommended that BSSLC review the existing Action Plan to identify areas in which qualitative criteria would be advantageous.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 10/07/2013 through 10/11/2013. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, it was determined that Provisions K.2, K.3, and K.11 were in substantial compliance with the Settlement Agreement. Despite the lack of substantial compliance with other Provisions, the review process did reflect that the Facility had achieved progress in other areas. Examples in which the Facility had achieved some positive outcomes included the following. • The Facility continued to strive toward all qualified staff becoming certified as behavior analysts. At the time of the site visit, 100% of eligible staff were either board certified or actively pursuing board certification. • The Facility had established a peer review process that was comprehensive and rigorous. • Efforts to collect and monitor behavior treatment data had improved, including the addition of monthly review of all behavior data by BCBAs. • The quality of behavior interventions had improved substantially. In those cases where individuals presented with mental illness as well as behavior challenges, the Behavior Services Department demonstrated particularly adept skills in integrating the assessment of both issues. Examples in which the Facility had not achieved progress included the following. • Although a number of individuals were provided with current intellectual and adaptive skill testing, such testing had slowed. • A substantial portion of individuals newly admitted to the Facility was not provided with timely assessments. • Counseling plans lacked a basis in evidence-based practices.

#	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	Historical Perspective During the baseline site visit, BSSLC employed no Behavior Services staff who were certified as a behavior analyst. Two members of the department were in the process of completing the course work and/or supervision required for certification. A third individual had obtained a graduate degree from a behaviorally-oriented program but was not pursuing certification.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>In January 2012, only two psychologists were BCBAs. Of the remaining Behavior Services staff, 13 met the criteria for pursuing board certification; only five were pursuing board certification.

At the time of the July 2012 site visit, only one BCBA remained on staff at BSSLC--Dr. Terry Blackmon, Chief Psychologist.

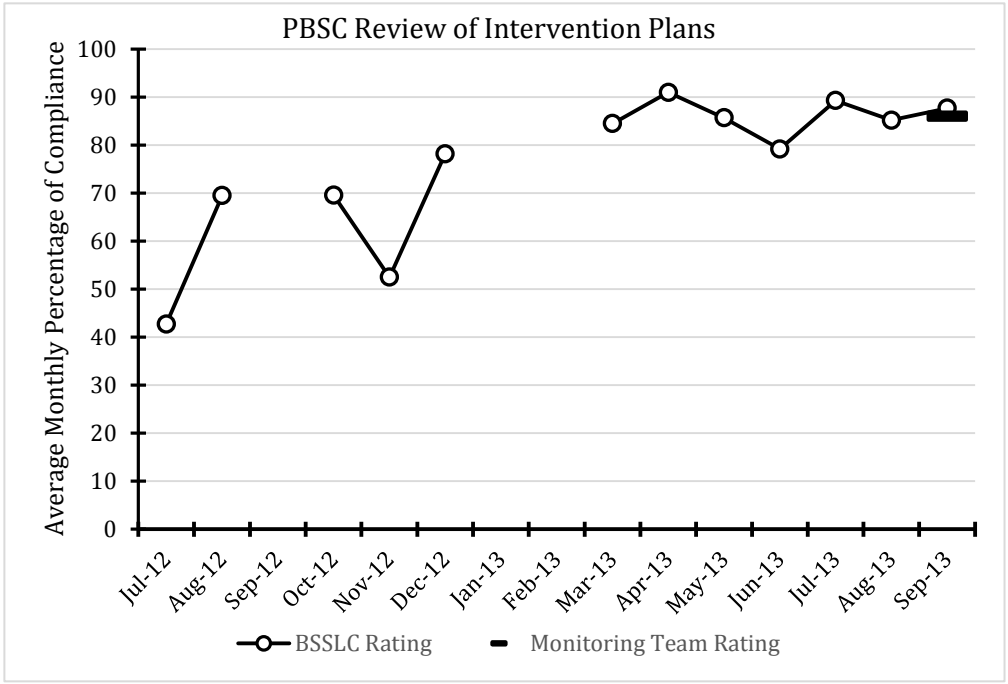
In April 2013, the Facility employed five Board Certified Behavior Analysts, including the Chief Psychologist, out of 13 staff eligible to participate in classes and sit for the board certification exam. Of the remaining eight staff lacking board certification, only one was currently enrolled in BCBA courses.

<u>Current Site Visit</u>
During the current site visit, Facility records regarding Behavioral Services Department staff were reviewed. These records reflected that four of 14 staff (29%) were board certified as a behavior analyst. Of the remaining ten staff, eight (80%) were actively pursuing board certification. Therefore, it was determined that 86% of the current Psychology Department staff either possessed or were actively pursuing board certification.

<table><tr><td></td><td>1/2010</td><td>4/2013</td><td>10/2013</td></tr><tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>38%</td><td>29%</td></tr><tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>26%</td><td>13%</td><td>80%</td></tr><tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>26%</td><td>46%</td><td>86%</td></tr></table>
The Facility reported that beginning on 2/15/2013 all behavior intervention plans were developed by a BCBA. Since that date, BCBAs at BSSLC had developed at least 131 intervention plans.

Although not in Substantial Compliance, the available documentation reflected that BSSLC had increased efforts to ensure that staff had or were progressing toward board certification. In addition, the continued use of BCBAs in intervention development was commendable.</td><td></td></tr>
<tr><td>K2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a</td><td>At the time of the site visit, BSSLC employed a full-time director of Behavioral Services--Terry Blackmon, Ph.D. Dr. Blackmon was extensively experienced in the field of intellectual and developmental disabilities, was licensed as a Psychologist in Tennessee, and had earned board certification as a behavior analyst. Based upon her credentials and</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	demonstrated competence, the employment of Dr. Blackmon by BSSLC satisfies this Provision of the Settlement Agreement.	
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.	Historical Perspective It was noted at baseline that BSSLC lacked a fully functioning internal peer review process. It was noted during the January 2011 site visit that progress had been made regarding peer review, but that substantial limitations continued. Specifically, the Peer Review Committee often failed to recognize the need for and require the application of a consistent and empirical model for behavior assessment and intervention. The failure of the committee to offer acceptable instructions and promote the use of behavior analytic practices was likely to undermine the intended goals of the peer review process. Observations and document reviews in July 2011 reflected that the Facility had progressed regarding external peer review. A contract had been signed with Texas State University for behavior consultation and external peer review services. During the January 2012 site visit, it was apparent that the steps taken by BSSLC since July 2010 to address peer review weaknesses were robust and extensive. There remained, however, weaknesses within the peer review process including the lack of a system to track the global changes in PBSPs as a measure of the peer review process. Reviews conducted during the July 2012 site visit revealed only modest improvements in the peer review process at BSSLC. A review of 20 recent PBSPs revealed a continuation of the deficits noted during previous site visits, such as poor rationale for interventions, limited use of appropriate training procedures for replacement behaviors, and a lack of treatment expectations. The April 2013 site visit revealed substantial improvements in the peer review process at BSSLC. PBSC meetings were more comprehensive with ample contributions from a variety of disciplines. In addition, data suggested that the quality of PBSPs had improved because of the PBSC review. Current Site Visit During the current site visit, observations were conducted during the PBSC meeting. The meeting was attended by all members, all of whom contributed to the review process by asking questions and offering comments. Overall, the actions of the committee members reflected a careful review of assessments according to behavior analytic principles. It was particularly noteworthy that comments offered by the psychiatric and speech-language staff reflected considerable familiarity with behavior analytic principles. A review of PBSC minutes from meetings held between 4/15/2013 and 9/3/2013 reflected that	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		discussion observed during the site visit was representative of the typical level of consideration at all PBSC meetings. The Facility had implemented a rubric as part of the peer review process in July 2012. Rubric ratings for all PBSPs listed in the Psychology Department tracking database from April 2013 through September 2013 were reviewed as part of the current site visit. This documentation reflected that intervention plans at BSSLC were consistently rated at between 80% and 90% of full compliance at the time of initial submission to the PBSC. Furthermore, a review by the Monitoring Team of the intervention plans submitted during September 2013 resulted in ratings within two percentage points of the ratings provided by the Facility.  The Facility provided documentation of two forms of external peer review. In the first method, each month, the intervention plan with the highest ratings from internal peer review was submitted for review by board certified behavior analysts who were on faculty at Texas State University. The second format for external peer review involved a Grand Rounds presentation of at	

#	Provision	Assessment of Status	Compliance
		least one case from each residential unit at BSSLC. Case presentations were conducted by Behavior Support staff during a meeting at BSSLC attended by the Texas State University faculty. The Texas State University faculty then offered recommendations regarding assessment and intervention. The first Grand Rounds was held in June 2013, with the plan to provide at least one meeting per semester. Based upon information obtained during the site visit, it was evident that BSSLC had developed and implemented a robust peer review process. Review of behavior assessment and intervention was comprehensive and multidisciplinary. Furthermore, data reflected that peer review procedures were instrumental in increasing the quality of behavior interventions. As a result, the Facility was determined to be in substantial compliance with the Settlement Agreement for this Provision.	
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.	<u>Historical Perspective</u> During both the baseline visit and first compliance visit, data collection for PBSPs consisted primarily of narrative reporting. At the time of the second compliance site visit, BSSLC had implemented a new data collection process using partial-interval data collection rather than narrative reporting. It was recommended at that time that BSSLC continue to add to the available data collection tools and procedures. In January 2012, a sample of 18 records reflected that some areas of behavior data collection had improved substantially. Efforts at IOA and treatment integrity monitoring, however, were sporadic. It was also noted during the January 2012 site visit that the Facility was not adequately monitoring treatment outcomes. Furthermore, in only 33% of reviewed PBSPs was there evidence that the Facility acted in a timely manner when individuals had not shown improvement in undesired behavior. During the July 2012 site visit, BSSLC demonstrated progress in relation to individually analyzed target behaviors, graphing of treatment data, and timely revisions of PBSPs. None of the items monitored as part of the Settlement Agreement review process had approached the levels necessary for substantial compliance. In April 2013, the increased number of BCBAs allowed the monthly review of PBSP data to be conducted by BCBAs. In addition, the Facility had initiated the use of a spreadsheet tracking system to coordinate and track PBSP reviews. <u>Current Site Visit</u> During the current site visit, a sample of 15 individuals was selected for review of data collection and treatment monitoring. This sample included Individuals #27, #35, #51,	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
#52, #133, #167, #255, #299, #349, #390, #408, #425, #484, #490, and #590.

The table below reflects the results from the current site visit review regarding the collection and presentation of data.

<table>
<tr><th></th><th>Baseline</th><th>10/2013</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>80%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>87%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>33%</td></tr>
<tr><td>Target behaviors analyzed individually</td><td>0%</td><td>73%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>60%</td><td>73%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making</td><td>0%</td><td>80%</td></tr>
</table>

Information gained from the record sample reflected that BSSLC had achieved substantial improvement in five of the six areas (83%). In the remaining area, a modest increase in scores was noted.

The availability and presentation of treatment data is only one aspect of the process of monitoring the benefit of intervention plans and psychotropic medications. It is also necessary to conduct thorough reviews of the available data and to introduce changes in the treatment process when data indicate changes are necessary. The information submitted during the current site visit to BSSLC reflected that the Facility continued to achieve progress in some areas. In other areas, however, submitted documentation did not reflect that the Facility had developed the practices necessary to ensure that all individuals received effective interventions.

<table>
<tr><th></th><th>Baseline</th><th>10/2013</th></tr>
<tr><td>Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level</td><td>0%</td><td>100%</td></tr>
<tr><td>Review is conducted by a BCBA</td><td>0%</td><td>100%</td></tr>
<tr><td>Input from direct care staff is solicited and documented</td><td>0%</td><td>7%</td></tr>
<tr><td>Modifications to the PBSP reflect data-based decisions</td><td>0%</td><td>47%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

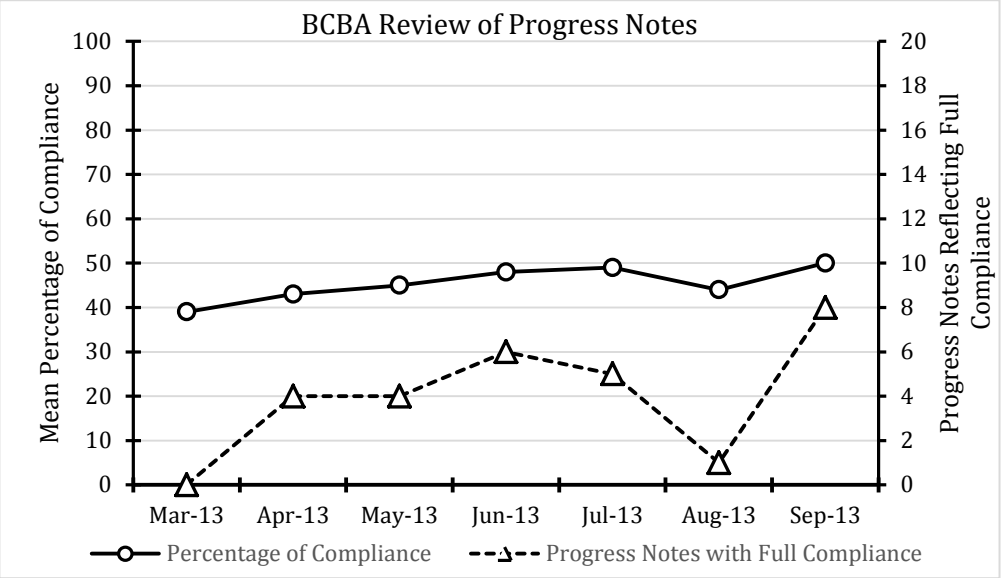
Criteria for revision are included in the PBSP	0%	87%
Progress evident, or program modified in timely manner (3 Months)	0%	60%

Six of 15 data records (40%) did not reflect that modifications to intervention plans were timely or evidence-based. In some of these six records, errors in the data presentation or discussion prevented the determination of whether appropriate treatment decisions had been made. For example, Individual #590 had more targets presented in the data graph than in the data table or graph legend, making it unclear what was being tracked and how treatment decisions were to be made. Some of these six records did include clear data graphs, and the data depicted therein did not reflect that adequate treatment decisions had been offered.

- The data for Individual #349 depicted several cycles of increased physical aggression and inappropriate sexual contact during the past year. These data suggested that the cycles were becoming longer and included behavior of increasing intensity. Documentation indicated that no changes in treatment had been attempted since December 2012.

Only one of the fifteen records reflected input from or consideration of the direct support staff. Anecdotal reports from any source do not constitute treatment data. It is important, however, to ensure that data have social validity. If direct support staff do not perceive changes in behavior that are shown in the data, it may be necessary to revise data targets or identify the reason for the discrepancy. Such a discrepancy may reveal, among other possibilities, that the changes in the behavior are not clinically significant or are not functional in meeting an individual's needs, that the particular type of data being taken does not adequately reflect the actual occurrence of the behavior, or that staff perception is inaccurate and staff need to see more information about what is occurring.

The Facility reported that the review of all BAIP data and progress notes by BCBAs that had begun in March 2013 had continued. Tracking tools reflected that nearly 100% of all notes and data were reviewed each month. In addition, ratings made by the BCBAs as part of the review reflected on-going improvement in the quality of progress notes and data.

#	Provision	Assessment of Status	Compliance
		 It was evident during the site visit that substantial effort had been made to improve behavior data and the use of data in the treatment monitoring process. Although these efforts had provided for substantial progress in several areas, the Facility continued to demonstrate some limitations in ensuring that all behavior data were presented and used in a satisfactory manner.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	<u>Intellectual and Adaptive Assessment</u> Intellectual and adaptive testing results play an integral role in understanding an individual. While a functional assessment may provide vital information regarding a single behavior or functional class of behaviors, intellectual and adaptive testing can prove useful in the development of teaching programs. To be useful, however, it is important that the tests be relatively recent, within one year for adaptive testing and five years for intellectual testing. In addition, interpretation of the results of the tests must go beyond the reporting of scores and elaborate upon specific abilities and limitations, as well as how those abilities and limitations are manifested in the person's daily activities. <u>Historical Perspective</u> In July 2010, it was noted that neither adaptive nor intellectual assessments were conducted at the Facility. This was attributed to the fact that BSSLC did not employ a psychometrist or psychologist with the credentials necessary for intellectual or adaptive assessment. In January 2011, BSSLC reported no substantive improvements since the	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>previous site visit in relation to psychological evaluation reports. During the July 2011 site visit, BSSLC indicated that a contract with Robert Guercio, MA, had been approved and that 60 intellectual and adaptive assessment reports had been completed. In January 2012, the total number of intellectual and adaptive behavior assessments had increased to 94. In July 2012, the number of individuals with an intellectual assessment within the past five years had increased to 153. Only 90 individuals had an adaptive skills assessment completed within the previous 12 months. In April 2013, the tracking tools provided by BSSLC reflected that 15 individuals, 5% of the 293 individuals living at the Facility, had received both current intellectual and current adaptive behavior assessments. Of the individuals listed in the Facility tracking tool, 68 (23%) were considered to have a current intellectual assessment and 43 (15%) were identified as having a current adaptive behavior assessment.

<u>Current Site Visit</u>
During the current site visit, a sample of 16 individuals was selected for review of Psychological testing and reporting. This sample included Individuals #35, #76, #106, #141 #158, #165, #187, #251, #263, #288, #314, #425, #471, #517, #521, and #536.

<table>
<tr><th></th><th>1/2010</th><th>4/2013</th><th>10/2013</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>35%</td><td>94%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>18%</td><td>94%</td></tr>
<tr><td>The Psychological Assessments contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>18%</td><td>75%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>0%</td><td>18%</td><td>69%</td></tr>
</table>

In addition to providing intellectual and adaptive assessments, it is crucial that the findings of those assessments be presented in a manner that goes beyond the reiteration of scores and facilitates the identification of personal strengths and limitations. A sample of 16 records was selected to determine the degree to which this was achieved.

<table>
<tr><th></th><th>1/2010</th><th>4/2013</th><th>10/2013</th></tr>
<tr><td>Psychological Assessments included a narrative summary of how the results from intellectual</td><td>0%</td><td>18%</td><td>69%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

assessments would facilitate the understanding of the individual's strengths and needs.			
Psychological Assessments included a narrative summary of how the results from adaptive assessments current or otherwise would facilitate the understanding of the individual's strengths and needs.	0%	18%	63%

Based upon the information obtained from the sample, the Facility demonstrated considerable progress. During the site visit, however, the Facility reported that DADS had informed BSSLC that no further intellectual assessments were to be completed without authorization from DADs. If the Facility understanding was accurate regarding those instructions, it appeared that the progress achieved by the Facility was temporary. Following the visit, the Monitoring Team was informed that in "local policy as well as the state policy, testing IQ is not limited by a time frame but based on the individual's need as determined by the team" but that "children will have an updated IQ test every 3 years" and that the Director of Behavioral Services coordinates the testing with the DADS Behavioral Services Discipline Coordinator to permit contact with the Coordinator for Continuity of Services, as changes in IQ can affect availability of community services.

Behavior Assessment
Historical Perspective
During the first two site visits to BSSLC, Behavior Services staff had not routinely employed strategies of assessing behavior that comported with acceptable practices within applied behavior analysis. In January 2011, the Facility demonstrated substantial progress in revisions to the Structural and Functional Assessment format. During the July 2011 site visit, BSSLC indicated that further revisions had been made to the process of assessing behavior and mental illness, including the addition to the SFA of sections for setting events, precursor behaviors, formal preference assessments, and physiological issues. In January 2012, the Facility was able to demonstrate substantial progress in relation to the SFA. By July 2012, however, the Facility had lost much of the previously gained progress. The majority of areas rated reflected substantial declines in performance. Of particular concern was the increased reliance upon abbreviated SFAs, the lack of direct observation in the assessment process, and the failure to integrate findings into a coherent hypothesis regarding the behavioral function. In April 2013, the Facility demonstrated broad improvement in the assessment of behavior, but continued to experience difficulty in the integration of psychiatric and behavior assessments.

Current Site Visit
During the current site visit, 15 records were selected as a sample of Structural and

#	Provision	Assessment of Status	Compliance
		Functional Assessments (SFAs) at BSSLC. This sample included Individuals #51, #52, #75, #106, #112, #141, #163, #263, #288, #304, #360, #425, #484, #496, and #521. . The ratings for those 15 individuals are presented in the table below.	

	1/2010	4/2013	10/2013
Assessment or review of biological, physical, and medical status	0%	100%	100%
Review of personal history	0%	100%	100%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	100%	100%
The process or tool utilizes both direct and indirect measures	0%	92%	100%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	92%	100%
Identification of antecedents relevant to the undesired behavior	0%	92%	100%
Identification of consequences relevant to the undesired behavior	0%	92%	100%
Identification of functions relevant to the undesired behavior	0%	75%	100%
Summary statement identifying the variable or variables maintaining the target behavior	0%	67%	100%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	75%	100%
Identification of preferences and reinforcers	0%	100%	100%

The reviewed records reflected no meaningful reductions in ratings in comparison with the previous site visit. Furthermore, BSSLC had achieved considerable improvement in the three areas noted as weaknesses in the previous site visit. Overall, the Behavioral Services Department at BSSLC demonstrated exceptional skill in the assessment of operant behaviors.

It was noted during the previous site visit that the Facility had achieved progress in relation to integrating mental illness into the assessment of operant behavior. The

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Facility continued to progress in this area at the time of the current site visit.

<table>
<tr><th></th><th>1/2010</th><th>4/2013</th><th>10/2013</th></tr>
<tr><td>Screening for psychopathology, emotional, and behavioral issues</td><td>0%</td><td>58%</td><td>100%</td></tr>
<tr><td>Differentiation between learned and biologically based behaviors.</td><td>0%</td><td>33%</td><td>100%</td></tr>
<tr><td>Identification of behavioral indices of psychopathology</td><td>0%</td><td>33%</td><td>100%</td></tr>
<tr><td>Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities</td><td>0%</td><td>17%</td><td>100%</td></tr>
</table>

All of the sixteen records reviewed (100%) included a review of psychiatric symptoms, as well as a Case Formulation section that presented psychiatric information. This review was comprehensive, and the Facility applied behavior assessment strategies for behavioral correlates of mental illness as adeptly as they demonstrated concerning operant behaviors. The progress achieved in this area was noteworthy.

Based upon the available information, it was evident that BSSLC had achieved considerable progress in Provision K5. If the Facility continues to progress in conducting psychological assessments and analyzing/summarizing the results, substantial compliance should be achievable in the near future.</td><td></td></tr>
<tr><td>K6</td><td>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.</td><td>As noted in Provision K5, 76% of individuals in the reviewed sample had a current intellectual assessment, while 71% had a current adaptive behavior assessment. A review of the BSSLC tracking data revealed that 206 of 288 individuals living at the Facility (71.5%) had a current intellectual assessment, while 161 of 288 individuals (55.9%) had a current adaptive skill assessment.</td><td>Noncompliance</td></tr>
<tr><td>K7</td><td>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</td><td><u>Historical Perspective</u>
In April 2013, the Behavior Services department continued to have Robert Guercio, MA complete intellectual and adaptive assessments, and incorporate the findings of those assessments into psychological evaluation reports.

<u>Current Site Visit</u>
At the time of the current site visit, 10 individuals had been admitted to the Facility since the previous site visit. Of those 10 individuals, three (30%) had been provided</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>psychological assessments, including findings of intellectual and adaptive ability testing, within 30 days following their admission.

<table>
<tr><th>Record</th><th>Admission Date</th><th>Intellectual Assessment Date</th><th>Adaptive Skill Assessment Date</th></tr>
<tr><td>215</td><td>5/17/2013</td><td>7/29/2013</td><td>7/31/2013</td></tr>
<tr><td>231</td><td>5/8/2013</td><td>No Date</td><td>No Date</td></tr>
<tr><td>240</td><td>6/11/2013</td><td>No Date</td><td>No Date</td></tr>
<tr><td>248</td><td>7/15/2013</td><td>7/31/2013</td><td>7/31/2013</td></tr>
<tr><td>251</td><td>6/24/2013</td><td>No Date</td><td>No Date</td></tr>
<tr><td>263</td><td>6/18/2013</td><td>8/23/2013</td><td>8/23/2013</td></tr>
<tr><td>357</td><td>7/9/2013</td><td>No Date</td><td>No Date</td></tr>
<tr><td>384</td><td>7/30/2013</td><td>8/22/2013</td><td>8/22/2013</td></tr>
<tr><td>439</td><td>9/9/2013</td><td>No Date</td><td>No Date</td></tr>
<tr><td>580</td><td>8/28/2013</td><td>8/29/2013</td><td>8/30/2013</td></tr>
</table>

As noted in Provision K.6, a substantial portion of the individuals living at BSSLC lacked intellectual and adaptive skill assessments. The table above reflects that recent admissions to the Facility were less likely to obtain timely assessments than those already residing at BSSLC. Therefore, the Facility was not in compliance with Provision K.7 of the Settlement Agreement.</td><td></td></tr>
<tr><td>K8</td><td>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.</td><td><u>Historical Perspective</u>
On April 1 2011, BSSLC entered into a contract with a Licensed Professional Counselor. The contract involved the provision of counseling services for individuals living at BSSLC. By July 2012, BSSLC had identified seven individuals as being involved in counseling: Individuals #11, #20, #185, #321, #399, #467, and #479. A review conducted of the treatment plans for each of the seven individuals reflected no change in the treatment plans or services delivered since July 2011. In April 2013, a full-time employee had been hired to provide counseling services. At the time of the site visit, however, no individuals had been identified as in need of counseling services and no counseling plans had been developed.

<u>Current Site Visit</u>
A sample of 13 individuals was selected for the review of Provision K.8. These individuals included five individuals with counseling plans (Individuals #206, #243, #360, #539, and #582), five individuals with Psychiatric Support Plans (Individuals #158, #187, #288, #517, and #536), and three individuals with Environmental Support Plans (Individuals #35, #141, and #165).</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The table below represents the overall ratings for all reviewed non-PBSP interventions.	

	4/2013	10/2013
Needed services (other than PBSPs, e.g. counseling) identified in the psychological assessment are implemented within 6 weeks of the assessment.	0%	62%
Service/treatment plan includes initial analysis of problem or intervention target, and a plan of service (e.g., curriculum or approach, frequency or planned number of sessions, statement of skill or intervention target)	0%	62%
Services are goal directed with measurable objectives and treatment expectations.	0%	62%
Services reflect evidence-based practices.	0%	62%
Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session.	0%	62%
Service plan includes "fail criteria"—criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention.	0%	62%
Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate.	0%	62%
Service is identified in ISP and, if applicable, PBSP.	0%	62%
Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	0%	100%
Staff who assist in therapy, or who supervise homework or milieu activities, receive	0%	62%

#	Provision	Assessment of Status	Compliance

training and monitoring from qualified therapists		

When broken down by the type of intervention plan, it was apparent that the counseling plans were the basis for the low ratings.

	Counseling Plans	Psychiatric Support Plans	Environmental Support Plans
Needed services (other than PBSPs, e.g. counseling) identified in the psychological assessment are implemented within 6 weeks of the assessment.	0%	100%	100%
Service/treatment plan includes initial analysis of problem or intervention target, and a plan of service (e.g., curriculum or approach, frequency or planned number of sessions, statement of skill or intervention target)	0%	100%	100%
Services are goal directed with measurable objectives and treatment expectations.	0%	100%	100%
Services reflect evidence-based practices.	0%	100%	100%
Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session.	0%	100%	100%
Service plan includes "fail criteria"—criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention.	0%	100%	100%

#	Provision	Assessment of Status				Compliance
		Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate.	0%	100%	100%	
		Service is identified in ISP and, if applicable, PBSP.	0%	100%	100%	
		Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	100%	100%	100%	
		Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists	0%	100%	100%	

Both the Psychiatric Support Plans and the Environmental Support Plans very closely mirrored the BAIPs. As a result, these plans were able to meet the criteria for Provision K.8. The weaknesses noted in the counseling plans included the following.

- No plans out of five (0%) included any indication that the individual had been referred for counseling by the IDT or that the need for counseling was included in the ISP. The Facility reported that a formal referral process was not in place.
- No plans out of five (0%) included a specific approach to intervention that was reflected throughout the plan.
- No plans out of five (0%) included measureable objectives and treatment expectations.
- No plans out of five (0%) included an evidence-based approach to treatment. Although at times targets for intervention were included, these targets were not adequately defined or were not reflected in the data collection for the plan.
- No plans out of five (0%) included fail criteria.
- No plans out of five (0%) included specific plans for generalization and maintenance.
- Five plans out of five (100%) included the indication that the counseling would be conducted by a Licensed Professional Counselor.
- No plans out of five (0%) included indications of the need for or qualifications of additional staff who might be required to implement portions of the counseling plan.

As the Facility had reported that several specific procedures had not been implemented

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>for plans included in Provision K.8, it was not surprising to identify weaknesses. Considerable effort will be required to address the weaknesses noted in the counseling plans. The quality and sophistication of the Psychiatric Support Plans and Environmental Support Plans</td><td></td></tr>
<tr><td>K9</td><td>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.</td><td><u>Historical Perspective</u>
At the time of the July 2011 site visit, the Facility indicated that substantial limitations existed in the PBSPs; specifically it was reported that PBSPs had not improved since the previous site visit in January 2011. PBSPs were noted to include the limitations such as poor rationale for interventions, limited history of interventions, inadequate intervention strategies, a lack of baseline data, and limited instructions for data collection. In January 2012, documentation reflected substantial improvement in several areas of Provision K9. The site visit review in April 2013 revealed continued improvement. In addition, the Facility presented a new combined format for behavior assessment and intervention called the Behavior Assessment and Intervention Plan (BAIP).

<u>Current Site Visit</u>
During the current site visit, 15 records were selected as a sample of Structural and Functional Assessments (SFAs) at BSSLC. This sample included Individuals #51, #52, #75, #106, #112, #141, #163, #263, #288, #304, #360, #425, #484, #496, and #521. The ratings for those 15 individuals are presented in the table below.

<table>
<tr><th></th><th>1/2010</th><th>4/2013</th><th>10/2013</th></tr>
<tr><td>Rationale for selection of the proposed intervention</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>History of prior intervention strategies and outcomes</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Consideration of medical, psychiatric and healthcare issues</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Operational definitions of target behaviors</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Operational definitions of replacement behaviors</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Description of potential function(s) of behavior</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Use of positive reinforcement sufficient for strengthening desired behavior</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Strategies addressing antecedent issues</td><td>0%</td><td>89%</td><td>100%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Strategies that include the teaching of desired replacement behaviors</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Strategies to weaken undesired behavior</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Description of data collection procedures</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Baseline or comparison data</td><td>0%</td><td>89%</td><td>100%</td></tr>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms</td><td>0%</td><td>0%</td><td>100%</td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Plan, or considerations, to reduce intensity of intervention, if applicable</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Signature of individual responsible for developing the PBSP</td><td>0%</td><td>100%</td><td>100%</td></tr>
</table>

The 15 BAIPs that were reviewed reflected sophistication and were substantially improved over previously reviewed intervention plans. It was evident that considerable effort had been invested in the progress achieved.

Despite the quality of the behavior interventions, there remained issues of concern regarding the provision of behavior support. During the current site visit, documentation submitted by the Facility for tracking PBSP implementation was used to determine if behavior interventions were implemented in a timely manner and if the necessary approvals were obtained for those behavior interventions. The documentation reflected that 86 PBSPs had been implemented since the end of the previous site visit. Of those 86 interventions, 13 (15%) had not been implemented and staff trained within the stipulated 14 days. Although it was positive that 85% of interventions had been implemented according to time stipulations, there could have been negative consequences for those individuals not receiving prompt intervention. This was especially true in consideration that two of the individuals whose interventions were delayed, Individuals #38 and #248, had been involved in multiple administrations of behavioral restraints.
</td><td></td></tr>
<tr><td>K10</td><td>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</td><td><u>Historical Perspective</u>
During previous site visits, BSSLC demonstrated consistent improvement in data graphing practices other than in relation to the presentation of IOA data. In January 2012, other than the lack of IOA data, the graphs were described as excellent. In July 2012, however, the sample of graphs reflected substantial declines in meeting criteria, including the presentation of IOA data, the proper development of vertical axes, and the</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>lack of condition change markers. In April 2013, it was noted that BCBAs had begun a monthly review of treatment data. In addition, although IOA observations had increased, the total number per individual remained low.

<u>Current Site Visit</u>
At the time of the current site visit, the Facility reported that BCBA monthly review of BAIP data had continued. Details about the BCBA data monitoring process is included in Provision K.4.

Treatment integrity and IOA data were reported for 157 individuals. The data reported included 1,954 treatment integrity assessments and 264 IOA observations conducted between 4/1/2013 and 9/30/2013. The results of the treatment integrity assessment indicated that BAIPs were implemented with an average of 97.97% compliance. IOA sessions revealed an average agreement of 97.9%.

No specific information was provided for determining the frequency of treatment integrity assessments and IOA observations. For the 157 BAIPs included in treatment integrity assessments, each was provided an average of two assessments per month. Regarding the IOA observations, each BAIP was provided an average of .28 observations per month. It was not evident that these procedures were conducted with the frequency needed to ensure that data were reliable and that BAIPs were implemented by all relevant staff with a high degree of integrity.

During the current site visit, a sample of 15 individuals was selected for review of data collection and treatment monitoring. This sample included Individuals #27, #35, #51, #52, #133, #167, #255, #299, #349, #390, #408, #425, #484, #490, and #590.

The table below reflects the results from the current site visit review regarding the collection and presentation of data.

<table>
<tr><td>Graph Element</td><td>1/2010</td><td>7/2012</td><td>10/2013</td></tr>
<tr><td>IOA for target behavior data</td><td>0%</td><td>10%</td><td>33%</td></tr>
<tr><td>IOA for replacement behavior data</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>IOA meets minimum expectations</td><td>0%</td><td>10%</td><td>0%</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>75%</td><td>60%</td><td>87%</td></tr>
<tr><td>Horizontal axis and label</td><td>75%</td><td>100%</td><td>93%</td></tr>
<tr><td>Vertical axis and label</td><td>75%</td><td>80%</td><td>93%</td></tr>
<tr><td>Condition change lines</td><td>75%</td><td>0%</td><td>93%</td></tr>
<tr><td>Condition labels</td><td>75%</td><td>0%</td><td>93%</td></tr>
</table>
</td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Data points and path</td><td>75%</td><td>100%</td><td>93%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>33%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>75%</td><td>80%</td><td>93%</td></tr>
</table>

The review reflected improvement over previous site visits concerning graph components. Percentages for data graph components were suppressed by graphs for Individual #590 that included more targets than were identified in the graph legend and for which it was not possible to determine whether the graph components were appropriate.

Despite the 264 IOA observations reported by the Facility, few progress notes contained information about reliability measures. None of the graphs reflected IOA information or included any information about treatment integrity.

Based upon information provided, although areas of progress were identified, the Facility had not achieved compliance with the Settlement Agreement.</td><td></td></tr>
<tr><td>K11</td><td>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.</td><td>In an attempt to ensure that all BAIPs are easily read and interpreted by staff, BSSLC required that the staff instructions section of each BAIP be written at 8th grade level or below. To ensure this requirement was met, BAIPs were not granted final approval by the PBSC until software for determining readability had shown this goal to be achieved. A review of tracking data revealed that average readability level for all 53 BAIPs reviewed by the PBSC since the last site visit was grade 7.6 with a range of grade 5.9 to grade 8.9.</td><td>Substantial Compliance</td></tr>
<tr><td>K12</td><td>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.</td><td>Documentation provided by the Facility indicated that 91 of 91 Direct Support Professionals (100%) hired since April 2013 were provided with training on Positive Behavior Support during the New Employee Orientation. In addition, since the previous site visit 251 Direct Support Professional staff were provided with training based upon the behavioral foundation curriculum at BSSLC. This curriculum included didactic training, modeling, role-playing and direct feedback from behavior analysts. The curriculum was reviewed and was noted to contain comprehensive information about the basics of applied behavior analysis. Examples of outcome measures or tracking data were not available for review.

The Facility reported that training was provided to Direct Support Professional staff on 111 newly approved individual behavior intervention plans since 3/1/2013. Of these 111 plans, 15 plans (13.5%) were trained on or prior to PBSC approval. Of the remaining 96 plans, the minimum latency between approval and training was one day, with a maximum latency of 77 days. The average latency was 11.88 days. Documentation of</td><td>Noncompliance</td></tr>
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		training was not provided by the Facility. Ongoing training of behavior intervention plans was also provided. As discussed in Provision K.10, the Behavior Support staff conducted treatment integrity probes for behavior interventions. Treatment integrity data reflected 1954 probes for 157 individuals between 4/1/2013 and 9/30/2013. The results of the treatment integrity assessment indicated that BAIPs were implemented with an average of 97.97% compliance. Where necessary due to low integrity, treatment integrity probes included coaching, modeling and other training for staff. The information provided by the Facility indicated a variety of training approaches were utilized in supporting behavior intervention plans. It was not always clear, however, which staff were trained and if all necessary staff were provided training. For example, there were no indications that staff who were temporarily reassigned ("Pulled") were provided with training of all intervention plans prior to assuming duties. In addition, in relation to training on new intervention plans, there were no indications if training included all staff, if training was competency based, and if training included supervisors and other staff who were not Direct Support Professionals. Although the Facility had demonstrated considerable effort in this area, further work in documenting training and demonstrating that training was comprehensive and adequate was needed before substantial compliance could be attained.	
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.	At the time of the site visit, BSSLC employed four staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 72 individuals residing at the Facility and fell short of the required ratio of one BCBA for every 30 individuals. If all staff positions eligible for BCBA credentialing were filled by a BCBA, the Facility would have one BCBA for every 20 individuals residing at the facility. BSSLC currently employed 7.5 Psychological Assistants. This would be sufficient to meet the ratio of one assistant for every two BCBAs even if all qualifying positions were staffed by a BCBA.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment, 9/23/2013 2. BSSLC Action Plan, 9/19/2013 3. Presentation Book, October, 2013 4. DADS Draft Policy; Medical Care, dated 10/2/201 5. BSSLC Policy I4.b Administrative Death Review Committee, (no date) 6. BSSLC Policy I.4.c Clinical Death Review Committee, (no date) 7. BSSLC Death/Discharge Summaries for Deceased Individuals #138, #284, and #372 8. BSSLC Quality Improvement Death Review of Nursing Services and recommendations for Deceased Individuals: #15, #138, #284, and #372 9. BSSLC Unusual Incident Reports (URIs) for Deceased Individuals #15, #138, #284, and #372 10. Texas Department of State Health Services Vital Statistics Unit, Certificate of Death for Deceased Individuals #15, #138, #284, and #372 11. BSSLC Clinical Death Review Committee Meeting Minutes/Recommendations for Deceased Individuals #138, #284, and #372 (not provided for Individual #15) 12. BSSLC Administrative Death Review Committee Meeting Minutes/Recommendations for Deceased Individuals #138, #284, and #372 (not provided for Individual #15) 13. BSSLC Death Review Tracking Tools for Deceased Individuals #15, #138, #284, and #372 14. List of all medical providers at the Facility 15. Copy of all CME obtained within the past 12 months, by all medical providers at the Facility 16. Copy of medical license for two medical providers 17. Nurse practitioners practice agreement, 7/26/2012 18. Morning medical meeting minutes for the first meeting of each month during the reporting period (May through September, 2013) 19. List of all individuals who were prescribed a Do Not Resuscitate (DNR) order 20. For all individuals of the list of DNRs (Individuals #59, #87, #597, #273, #272): a. Most recent annual medical assessment b. Most recent ISP, or other relevant documentation indicating and interdisciplinary team (IDT) review c. Copy of ethics review for the DNR d. Copy of the consent for DNR e. Copy of the completed DNR form f. Copy of specific instructions to direct care, and other staff, regarding the DNR g. Copy of the medical providers interdisciplinary progress notes (IPN) documenting the clinical rational for the DNR 21. List of all individuals with diagnosis of malignancy, and history of malignancy 22. For the five individuals with diagnosis of malignancy (Individuals (#39, #19, #238, #444, #169): a. Annual medical summary b. Most recent two physician quarterly reviews c. Most recent IRRF

	d. All IDT related minutes specific for diagnosis of malignancy e. Last six months IPNs by the medical provider that specifically documented assessment of malignancy f. All consultation reports specific for the diagnosis of malignancy 23. Alpha list of all individuals with diagnosed seizure disorder 24. Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period 25. List of all individuals with diagnosis of intractable seizure disorder 26. List of all individuals with implantable VNS 27. For the first five individuals on the list of individuals with VNS (Individuals #361, #69, #428, #473, #437), copy of the most recent VNS interrogation report 28. For Individual #86: a. Annual medical summary b. Most recent two quarterly physician summaries c. Most recent two neurology consultation reports d. Current medication list e. Most recent EEG f. Most recent brain imaging report g. Current six months medical provider's IPNs, specific for management of seizure disorder h. IDT meeting minutes documenting supports and services necessary for the management of seizure disorder i. Seizure log 29. Alpha list of all individuals with a diagnosis of osteoporosis 30. For the first two and last three individuals on the list (Individuals #38, #272, #237, #84, and #280): a. Most recent medical assessment b. Quarterly physician assessments for past six months c. All documentation indicating assessment for the etiology of low bone density d. Most recent IRRF e. Current medication list f. Labs for past 12 months g. Consultation reports specific for the evaluation, and/or treatment of osteoporosis h. All diagnostic studies to assess for bone density, for the past three years 31. Alpha list of all individuals who sustained a fracture during the reporting period 32. Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures 33. For Individuals #243, #159, #87, #221, #377: a. Most recent annual medical assessment b. Past six months quarterly medical assessments c. PT/OT assessments, and IPNs specific for the management of fracture d. Medical provider's IPNs specific for the assessment and management of fracture e. Medical provider's IPN documenting the possible etiology of the fracture f. Most recent two IRRFs

	g. IDT minutes, ISP, or other documentation indicating an IDT review of the fracture h. Most recent bone density i. Most recent medication list 34. Complete vaccination records, and serology verification of immunization for Individuals #112, #270, #412, #286, #413, #167, #160, #45, #258, and #318. 35. List of all individuals 40 years old, and older 36. List of all individuals who were current and not current with their annual mammogram screen 37. Documentation by the Facility indicating the rationale why individuals were not current with their annual mammogram screen 38. List of all individuals 50 years old and older 39. List of all individuals who were current with their screening colonoscopy 40. List of all individuals who were not current with their screening colonoscopy 41. Documented rationale for each individual not current with screening colonoscopy 42. List of all men age 50 and older 43. For the last ten individuals on the list: a. Copy of their PSA test results b. Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing c. Rationale why annual PSA testing was not completed 44. For Individuals #206, #286, #187, #75, #206, #337, #38, #568, and #243: a. Medical provider's IPNs, specific for evaluation of the chronic care condition, during the past six month review period. b. Most recent IRRF c. Past 12 months clinical consultations, specific to the chronic care condition. d. Any diagnostics, including labs, and imaging studies, specific to the management of the chronic care condition, for the past 12 months. 45. Alpha list of all individuals who were diagnosed with pneumonia during the reporting period 46. Alpha list of all individuals who were diagnosed with recurrent pneumonia (more then three occurrence of pneumonia within the past five years) 47. For all individuals who experienced four or more cases of pneumonia with in the past five years: a. Most recent annual medical summary b. All quarterly physician reviews for the reporting period c. Most recent IRRF d. Most recent PT/OT assessment e. Medical diagnostic, and consultation reports, specific to the management of pneumonia 48. Most recent annual ISP for Individual #58 49. Post hospital interdisciplinary team meeting minutes for Individual #318 50. Internal and External Medical Audit summary for round 7 51. Round 7 completed Internal Medical Audit tool for all medical providers **People Interviewed:** 1. Mary Anne Brett, M.D., Medical Director 2. Debbie Williams, Chief Executive Nurse

	3. Daniel Dickson, Director of Quality Assurance 4. Jill Quimby, RN, Quality Assurance Nurse 5. Valerie Kipfer, RN, MSN, State Office Nursing Coordinator **Meeting Attended/Observations:** 1. Settlement Agreement Medical and Nurse Monitors met with Medical Director, Chief Executive Nurse, Quality Assurance Nurse, and Quality Assurance Director on 10/10/13 and reviewed/discussed deaths occurring over the last six months. 2. Post hospital discharge planning meeting for Individual #318 3. Annual interdisciplinary team meeting (IDT) for Individual #58
	Facility Self-Assessment: The Monitoring Team concurred with the Facility's self-assessment of non-compliance with sections L.1 through L.4. The self-assessment was mostly a list of items that the Facility had recently completed; did not rely on collecting, or reporting, of data elements; and furthermore, did not assess effectiveness of corrective action steps, or efficacy of clinical practice. The action plan did not provide insight into all of the necessary action steps that would help lead the Facility to substantial compliance. The Monitoring Team strongly recommends that the Facility develop a self-assessment process that tracks data-elements, assesses all necessary action steps required for substantial compliance, and ensures that the efficacy of clinical practice is assessed, not just procedural efforts.
	Summary of Monitor's Assessment: The Monitoring Team noted progress with medical provider's management of diabetes; participation at individual support plan (ISP) and Interdisciplinary Team (IDT) meetings; enhancement of examination rooms by providing modernized equipment, and examination tables; and maintaining a robust morning medical debriefing meeting to help ensure effective continuity of care. The Monitoring Team determined that the Facility was not in compliance with Section L, and must continue to enhance development and implementation of its clinical practice. The following are some of the Monitoring Team's concerns for Sections L.1 through L.4. Provision L.1: The Monitoring Team noted improved following up on the management of diabetes mellitus, and improvement with the medical provider's participation at IDT and ISP planning meetings. The Facility had enhanced its medical examination rooms, obtaining necessary clinical equipment and examination tables. Also noted was continued improvement with the morning debriefing meeting, which provides an effective process to help improve on continuity of care. The Monitoring Team concurs with the Facility's self-assessment, and determined noncompliance for Section L.1. The Facility must continue to enhance its clinical processes in the area of immunization, evaluation of DNR status, and following up on chronic clinical care issues. Provision L2: The Monitor Team compliments the Facility for conducting the external medical provider quality assurance audits; however, the Monitoring Team was unable to complete its assessment of the medical audit process because documents requested for the Facility's development, implementation and follow-up for action plans were not provided. The Monitoring Team recommends that the medical audit

	process be revised to reflect an assessment of clinical performance, by assessing medical providers practice standards as compared to generally accepted standard of care practice. The mortality review process must be significantly revised to ensure that medical providers conduct a comprehensive case review of all deaths, and that meaningful recommendations are provided for each death, derived by a root cause analysis. The Facility must conduct periodic analysis of all deaths, and when the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care. The Monitoring Team strongly recommends that all mortality reviews include a comprehensive review of clinical care, with the goal of identifying strategies to enhance the delivery of medical care at the Facility, and not focus on the immediate circumstance surrounding the death. Provision L3: Because the Facility had not developed a data-driven process to track and trend medical outcome indicators, for the purpose of enhancing clinical care at the Facility, the Monitoring Team determined noncompliance with Section L.3. The Facility must develop and implement a medical quality assurance process that tracks and trends positive outcomes and adverse outcomes for its medical practices. Furthermore, the process must include a mechanism for the development and follow-up of remediation efforts for all identified adverse outcomes and deficiencies. Provision L.4: Because the Facility did not develop or maintain necessary policies and procedures delineating its clinical practices, the Monitoring Team determined that the Facility is noncompliant with Section L.4. The Facility must develop, and implement functional policies and procedures to establish for medical providers, and other relevant staff, specific guidance on the Facility's practice standards of care.

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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	Provision L.1 comprehensively assesses the Facility's ability to provide medical care, at the level of generally acceptable standard of care practice. To assess the Facility's effort towards substantial compliance for Provision L.1, the Monitoring Team discussed medical compliance issues with the medical director; met with members of the Facility's medical staff; observed the Facility's clinics; and attended medical meetings, an annual individual support planning meetings (ISP), and a post hospital discharge planning meeting. Through document review, the Monitoring Team assessed the Facility's medical administration; immunization and vaccination; cancer screening; practice for do not resuscitate orders; clinical management of acute medical conditions; management of seizure disorder, and Vagal Nerve Stimulators; recurrent pneumonia; osteoporosis; and the management of chronic care conditions. <u>Medical Administration</u> The Monitoring Team assessed licensure status of the Facility's medical staff, clinical documentation practice, and the Facility's regularly scheduled interdisciplinary	Noncompliance

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	separate monitoring plan.	meetings. To help with the assessment the Monitoring Team reviewed the following documentation: • List of all medical providers, including number of hours worked, case load, and employment status • For each medical provider o Curriculum vita for all licensed medical providers o Copy of current medical license for two medical providers (the Monitoring Team requested all but received two) o Copy of current CPR certificate for all medical providers o List of all CME obtained during the past 12 months for all medical providers • Nurse practitioner agreement • Copy of morning medical meeting minutes for the first meeting of each month during the reporting period. Medical Providers: The Facility maintained one full time medical director, three full time medical doctors, and one nurse practitioner. Medical licenses were reviewed, and noted to be current for all licensed medical providers and the medical director. Of the five medical providers, one was a nurse practitioner who was directly supervised by the medical director, and co-supervised by staff physicians. The nurse practitioner practice agreement was signed by all relevant parties on 7/26/2012, and the Monitoring Team determined that a there were no related issues of concern with the practice agreement. All medical providers and the medical director were current with continuing medical education for general practice. Although requested, CPR certificates were not included in the documents received by the Monitoring Team, and copies of current medical licenses were provided for only two physicians. <u>Medical Meetings</u> The Facility conducted a daily medical meeting called the Morning Medical Debriefing. The Morning Medical Debriefing is chaired by the medical director and conducted five days per week. It is an integrated, multidisciplinary meeting that consists of medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, quality assurance, dental, and pharmacy services. The purpose of the meeting is to triage, and discuss urgent clinical issues to ensure continuity of care, and to enhance clinical management of individuals. Issues discussed include, but are not limited to: Medical on	

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		call report; hospital report; infirmary report; psychiatric; behavioral health related issues; pending medical consultations; wound care, and infectious disease issues; and significant medical conditions. Review of the meeting minutes for the morning medical meetings that occurred from on the first Monday of each month, from May 2013, to September 2013 indicated summary documentation of the events discussed at the meeting, and and there was indication that action plans were developed for relevant issues discussed during the meeting. There was no consistent indication that specific staff members were assigned responsibility to follow-up on each action plan; however, there was indication if action plans were completed or not completed. The Monitoring Team attended the October 8, 2013 meeting, and was impressed of the comprehensiveness, and efficiency of the meeting. The meeting enabled all members to gain greater insight into the clinical management of individuals reviewed during the meeting. Meeting minutes should be enhanced to ensure a standardized process for developing action plans for all relevant clinical issues, and a process to ensure that the action plans were completed, and implemented. Summary: The Facility did not provide copies of CPR or medical licenses for all practicing medical providers for review. The Facility maintains an efficacious morning medical debriefing meeting, that enables enhanced continuity of care. <u>Review of Do Not Resuscitate (DNR) Process</u> To assess the Facility's DNR process, the Monitoring Team requested the following information: • List of all individuals who were prescribed a DNR order • For all individuals on the list of DNRs (Individuals #59, #87, #597, #273, #272): o Most recent annual medical assessment o Most recent ISP, or other relevant documentation indicating and interdisciplinary team (IDT) review o Copy of ethics review for the DNR o Copy of the consent for DNR o Copy of the completed DNR form o Copy of specific instructions to direct care, and other staff, regarding the DNR o Copy of the medical providers interdisciplinary progress notes (IPN) documenting the clinical rational for the DNR Review of the requested documents indicated the following:	

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		• The annual medical summary clearly delineated the qualifying condition for the DNR in zero out of five examples (0%). Examples of issues related to qualifying conditions: o Individual #59: Individual #59 was diagnosed with a genetic condition, which can cause early mortality, although in some cases the individual may live to a normative age. Individual #59 is greater then 45 years old and has survived beyond the early mortality phase of this syndrome. The Facility had implemented a DNR listing iP36 deletion syndrome as the "terminal condition". The Facility should re-evaluate the qualifying condition for the DNR. o Individual #87: The Individual was diagnosed with refractory seizure disorder and a DNR was ordered in 2008 because of refractory seizures. Five years later, 2013, the Individual's overall health status had not changed secondary to refractory seizure. • In zero out of five examples (0%), the ISP clearly delineated the qualifying condition for the DNR, and all supports necessary to support the individual during an end of life event. In no examples did the ISP clearly document qualifying conditions, and list all necessary supports and services required to support the individual. The ISP for Individual #87 stated that the Individual was a "full code"; however, there was a copy of a DNR form in the active clinical record. • In zero out of five examples (0%) there was evidence of a comprehensive review for the DNR, which included a complete understanding of the qualifying condition, potential alternatives to DNR, and periodic review for the continued need of the DNR order. • In zero out of five examples (0%) there was a comprehensive IPN, or other document, completed by the medical provider documenting the qualifying condition and possible alternatives to the DNR. • The DNR form was fully completed in one out of five examples (20%). Some examples of DNR forms not being complete include: o The DNR form for Individual #87 was not signed by the "Guardian". o For Individual #597 and #273, there was only one medical provider's signature documenting the DNR, and there were no "Guardian" signatures. • The DNR form did allow for specific levels of DNR orders. The Monitoring Team did not understand the rationale for including an option to withhold nutrition, fluids, and antibiotics, on a DNR form. Such options are specific for palliative care related issues, and not immediate resuscitation. • There was no evidence to indicate that the Facility ensures that necessary supports and services were in place to address a terminal event. For example, if	

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		an individual had a DNR order in place because of congestive heart failure, the IDT should develop a treatment plan to address acute cardiac decompensation, and treatments for discomfort and pain during the final moments of life. • Documentation indicating that the DNR underwent an ethics review, within the past 12 months, was present in zero out of five examples (0%). Summary: The Monitoring Team determined that the Facility did not have a functional DNR process that enabled a meaningful ethics review, periodic assessment for the continued need for DNR, planning for end of life events for individuals with DNRs, and a process to assess for possible alternatives to DNR. <u>Clinical management of malignancy</u> To assess the Facility's ability to provide necessary clinical supports and services for individuals with diagnosed malignancy, the Monitoring Team reviewed the following documents: • List of all individuals with diagnosis of malignancy, and history of malignancy • For the five individuals with diagnosis of malignancy (Individuals #39, #19, #238, #444, #169): o Annual medical summary o Most recent two physician quarterly reviews o Most recent IRRF o All IDT related minutes specific for diagnosis of malignancy o Last six months IPNs by the medical provider that specifically documented assessment of malignancy o All consultation reports specific for the diagnosis of malignancy Most of the documents provided for review were not specific to assessment or follow-up of the individuals' diagnoses, which made the review extremely challenging. For example, the documents for Individual #39 included many IPNs by the medical provider that included follow-up on medical conditions other then malignancy. Also, several ISPs and addendum to ISPs were included that did not comment on malignancy, and there was an ISP for Individuals #169, and #19 within the documents for Individual #39. For Individual #444, the Facility provided many irrelevant IPNs, and scattered among the IPNs were multiple records of vital signs, and in the middle of the IPNs, were three consultation reports. For Individual #169, there was an email indicating that a "CT turned out fine", which had no relevance to the malignancy of the skin diagnosis, and the documents also included countless pages of hospital liaison reports for UTI, which again, had no relevance to the skin cancer. To ensure an accurate monitoring review, the Facility should provide the requested documents without extraneous documents; the	

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		Facility should seek guidance if it is unsure what is requested. Following is a summary of the Monitoring Team's review of the documents provided for Individuals #39, #19, #238, #444, #169: • One out of five examples (20%) indicated appropriate clinical assessment, and follow-up by the medical provider, for the diagnosis of malignancy. • Two of five examples (40%) indicated that clinically appropriate consultations were provided for the diagnosis of malignancy. For example, there was no documentation of period evaluation for malignancy of the skin for individual #169, #238; there was no consultation report by urology for Individual #19, or #39. • One out of five examples (20%) included the diagnosis of malignancy on the IRRF. • IDT minutes were provided for only one (Individual #444) out of the five examples (20%). The example was for an Individual who recently underwent a surgical resection for cancer treatment. • In one out of five (20%) of the examples, the medical provider documented regular follow-up monitoring possible recurrence of cancer. The following are some of the concerns noted by the Monitoring Team: • Individual# 39: o The annual medical assessment did not summarize the status of the Individual's prostate cancer. o There was no specific action plan to address prostate cancer. o The IRRF, and ISP did not comment on prostate cancer, and the medical examination did not comment on the Individual's testicular examination. The prostate examination indicated "normal exam", but the comment documented that the prostate was "not present". The only documented comment noted for the Individual's prostate cancer, was that he underwent removal of both testicles; however, there were no additional comments on other treatments the Individual underwent, such as possible resection of the prostrate, or possible chemotherapy, or radiation therapy. • Individual #19: The Individual was diagnosed with two different malignancies (prostate cancer and melanoma). For malignant melanoma of the skin, the only action plan documented on the annual medical assessment was to obtain an annual chest x-ray, and continue dermatology evaluations as recommended. There was no indication of regular monitoring for skin cancer, outside of seeing the dermatologist, and there was no documented instruction to protect the Individual from sun exposure. There were consult notes from dermatology	

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		assessing malignant melanoma, but there were no consult notes from urology. The IRRF and annual ISP did not document risks associated with low volume prostate cancer or malignant melanoma. • #Individual #238: There was no documentation of the treatment provided for the Individual's basal cell carcinoma, and no indication of follow-up with dermatology noted on the annual medical assessment. The only action plan documented was "continued observation; report any skin changes". The IRRF did not document risks associated with basal cell carcinoma. • Individual #444: The general surgeon made recommendations specific for fiber and fluid intake. These recommendations were not represented as recommendations on the IDT's weekly follow-up that occurred after the Individual's surgery, and there was no indication that the specific recommendations were followed. Summary: The Facility must enhance its process for following up on individuals with cancer diagnosis; ensure that all necessary supports and services are well documented; and ensure that the IDT is made aware of all risks associated with the diagnosis. It is also imperative that all past treatments for cancer have been fully documented on the annual medical assessment. <u>Management of seizure disorder</u> To assess the Facility's ability to clinically manage seizure disorder, the Monitoring Team reviewed the following documentation: • Alpha list of all individuals with diagnosed seizure disorder • Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period • List of all individuals with diagnosis of intractable seizure disorder • List of all individuals with implantable VNS • For the first five individuals on the list of individuals with VNS (Individuals #361, #69, #428, #473, #437), copy of the most recent VNS interrogation report • For all individuals diagnosed with intractable seizures (Only one example was provided, #86): o Annual medical summary o Most recent two quarterly physician summaries o Most recent two neurology consultation reports o Current medication list o Most recent EEG o Most recent brain imaging report o Current six months medical provider's IPNs, specific for management of	

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		seizure disorder o IDT meeting minutes documenting supports and services necessary for the management of seizure disorder o Seizure log The following is the Monitoring Team's summary of its document review of seizure management: • Zero out of one example (0%) included an accurate diagnosis for the seizure disorder. For example, the diagnosis listed for Individual #86 was "seizure disorder". The Monitoring Team noted that the list developed and provided by the medical director of all individuals with known seizure disorder, indicated a diagnosis of "generalized convulsive epilepsy" without mention of "intractable epilepsy" or "generalized epilepsy"; however, the annual medical assessments for Individuals #361, #69, #428, #473, and #437 documented "seizure disorder", and not the specific diagnosis that was indicated on the list provided by the medical director. The Facility must document an accurate diagnosis for seizure disorder, and ensure that the Facility's list of individuals with seizure disorder accurately corroborates the actual diagnosis. • Zero out of one example (0%) included a clinically appropriate medical action plan on the annual medical summary. The annual medical summary, including the medical action plan, did not comment on relevant issues related to seizure disorder, such as seizure frequency, efficacy of medication management, and necessary supports and services specific for seizure disorder. • One out of the one example (100%) indicated that the Individual was regularly followed by neurology. • Review of the first five examples from the list of individuals who had a VNS device (Individuals #361, #69, #428, #473, and #437) indicated that for three out of five individuals (60%), the VNS device was regularly interrogated by the neurologist. o Individual #361 was last interrogated on October 2011; and Individual #473 was last interrogated on November 2012 o The magnet was used within the interrogation period in zero out of five (0%) examples. o The interrogation form was fully completed in zero out of five examples (0%). • For zero out of one example (0%), IPNs by the medical providers indicated clinically appropriate medical follow-up, following reported seizure activity. There was no medical provider's IPN specific to the follow-up on active seizures experienced by the Individual.	

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		Clinical management of osteoporosis To assess the Facility's ability to clinically assess and treat osteoporosis, the following documents were requested, and reviewed: • Alpha list of all individuals with a diagnosis of osteoporosis • For the first two and last three individuals on the list (Individuals #38, #272, #237, #84, and #280): o Most recent medical assessment o Quarterly physician assessments for past six months o All documentation indicating assessment for the etiology of low bone density o Most recent IRRF o Current medication list o Labs for past 12 months o Consultation reports specific for the evaluation, and/or treatment of osteoporosis o All diagnostic studies to assess for bone density, for the past three years The following are the Monitoring Team's findings from review of the documents related to the management of the assessment and treatment of osteoporosis: • Five out of five examples (100%) included annual medical summaries that indicated a clinically appropriate diagnosis for osteoporosis on the active problem list. • In four out of five examples (80%) the annual medical summaries indicated a clinically appropriate action plan for osteoporosis: The annual medical assessment for Individual #38 did not include a comprehensive action plan to address the Individual's clinical issues, including osteoporosis. The only issues documented were "better control of Diabetes, Prevent Decubitus Ulcers, Maintain health with on campus care and referrals off campus as needed". The current health status section of the annual medical assessment did not comment on osteoporosis. • Zero out of five examples (0%) included documentation indicating a clinical evaluation for the etiology of low bone density. • Five out of five examples (100%) included evidence that a clinically appropriate diagnostic was obtained to assess bone density, and treatment efficacy, when clinically indicated. • Five out of five examples (100%) included evidence that a clinically appropriate pharmacological therapy was provided, as clinically necessary, to treat low bone density. • Five out of five examples (100%) included osteoporosis as a risk factor on the most recent IRRF.	

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		Clinical management of fractures The Facility reported ten individuals as having a fracture during the reporting period. To assess the Facility's clinical ability to manage fractures, the Monitoring Team requested the following information: • Alpha list of all individuals who sustained a fracture during the reporting period • Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures • For the first two and last three individuals on the list of fractures (Individuals #243, #159, #87, #221, and #377): o Most recent annual medical assessment o Past six months quarterly medical assessments o PT/OT assessments, and IPNs specific for the management of fracture o Medical provider's IPNs specific for the assessment and management of fracture o Medical provider's IPN documenting the possible etiology of the fracture o Most recent two IRRFs o IDT minutes, ISP, or other documentation indicating an IDT review of the fracture o Most recent bone density o Most recent medication list The Facility provided a spreadsheet documenting a total of 15 fractures that occurred between 3/19/2013 and 9/24/2013: • Two individuals (Individuals #566 and #221) sustained fractures on more then one occasion during this period. • Six out of 15 fractures required surgical intervention. • Two individuals sustained multiple fractures on the same occasion. o Individual #286 sustained three fractures, including right tibia, fibula, and malleolus. o Individual #566 sustained two fractures on 3/19/2013, which included the right hip and humerus, and a third fracture on May 22, 2013 that included the right femur. The spreadsheet of fractures indicated that the right femur fracture was a spiral fracture, and that the cause was determined to be an osteoporotic fracture. The Monitoring Team is unaware of the Facility's intention of indicating an osteoporotic fracture--if the fracture was a pathological fracture, and without associated external trauma, or was the fracture a traumatic fracture of an osteoporotic bone. Pathological fractures of the tibia are generally,	

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		but not always, associated with tibial-plataeu fractures, and not spiral fractures. The following is a summary of the Monitoring Team's findings for the document review related to the management of fractures: • The Facility did not provide committee meeting minutes, or other relevant documentation indicating that it conducts regular meetings to address fractures, and mechanisms to reduce fractures, as part of a system review at the Facility. • In zero out of five examples (0%) the medical provider conducted a prompt initial triage for reported fractures. There were no examples of the medical provider documenting initial evaluation of the fracture, with the exception of one example (Individual #159), and in that example, the medical provider did not assess the Individual until the following morning, which was approximately nine hours following the nurse's notification of a serious injury to the medical provider. • In zero out of five examples (0%) the medical provider regularly followed the Individual through full resolution of the fracture. • In five out of five examples (100%) the medical provider obtained necessary diagnostics and prompt consultation for the assessment and treatment of fracture. • In zero out of five cases (0%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. • In zero out of five cases (0%), PT/OT documented a comprehensive assessment of all risk factors for fall, and fracture. • In five out of five cases (100%), the IRFF documented a comprehensive assessment of all risk factors for fall and fracture. • In zero out of five cases (0%), there was documentation on the annual medical summary, quarterly physician reviews, PT/OT assessments, and ISPs, indicating that prescribed supports and services to help prevent falls and fractures were routinely assessed for efficacy. There were no examples of the medical provider's conducting quarterly medical assessments. PT/OT assessments and annual medical summaries reviewed did not specifically document all necessary supports and services necessary for prevention of falls and fractures. The following are some of the Monitoring Teams concerns for the five examples reviewed (Individuals #243, #159, #87, #221, #377): • Individual #243: The spreadsheet of fractures indicated that the Individual had sustained one fracture of the index finger, on 2/7/2013; however, IPNs provided for review indicated multiple healing fractures of the right hand, dated 8/15/2013. There were no IPNs provided documenting the medical provider's	

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		follow-up through resolution, or associated diagnostic or consultation reports for the fracture. • Individual #159: Injury that required nursing attention and medical provider notification occurred at 2301 on 8/8/2013, and was not evaluated by the medical provider until 0930 on 8/9/2013. Because there was clinical evidence of a fractured right hand, the Individual was triaged to the local emergency room at 1725, on 8/9/2013, at which time a fracture was confirmed. IPNs provided indicated that the medical provider did not follow-up with the Individual until 8/12/2013, and did not document a physical assessment, but indicated that the individual had two fractures of the right had and was scheduled to see orthopedic specialist. A subsequent IPN by the medical provider was dated 8/26/2013, indicating that the Individual was seen by the orthopedist and a cast was applied on 8/23/2013; hence, there was a 15 days delay from the time of the injury, to the reported time of follow-up with an orthopedic specialist. A medical provider IPN was documented on 9/13/2013 indicating that the Individual was seen by the orthopedist on 9/10/2013, and that the fracture had "not healed yet". On 9/30/2013 the medical provider's IPN documented that the individual was seen on 9/27/2013, and that the fracture had healed, and the cast was off. The medical provider did not document a physical examination upon return form the hospital, during the interim period of healing, or following removal of the cast. Furthermore, the medical provider did not document an assessment as to the cause of the fracture, if adequate supports and services were in place, or determine if pain was appropriately assessed. • Individual #87: The Individual was reported to have sustained a fracture of the right toe; however, the document request did not provide copies of IPNs, IDT meeting minutes, hospital, diagnostic, or consultation reports. • Individual #221: The Individual was reported to have sustained a fracture of the nasal bone on 2/13/2014. On 6/20/2013, there was a medical provider's IPN documenting that the Individual was to be sent to the ER for suture removal, and a second medical IPN documented that the Individual needed to continue to follow-up with the ENT specialist because of persistent swelling, and also stated that the Individual did not demonstrate problems with breathing. There were no additional medical provider's IPNs provided to determine initial assessment, and regular follow-up by the medical provider, through resolution. The Facility did not provide evidence indicating prompt initial triage of the fracture, or consultation and diagnostic reports. • Individual #377: There were four medical provider's IPNs provided for review; the first, dated 2/15/2013, documented the follow-up from the emergency room triage of the fracture, and three additional IPNs documenting follow-up with the orthopedic consultant, dated 2/26/2013, and 3/7/2013, and 6/11/2013. There	

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		were no medical provider's IPNs documenting a clinical assessment of the fracture, if all necessary supports and services were provided, if pain was appropriately assessed, or the suspected cause of the fracture. The medical provider did not participate at the IDT meeting for review and management of the fracture. PT/OT did not assess the Individual for necessary supports and services, secondary to the fracture. <u>Review of Immunizations</u> To assess the Facility's compliance with CDC guidelines for immunization, the Monitoring Team reviewed the following documents: • Complete vaccination records, and serology verification of immunization for the first individual on the current name key, as of this review, and than every fifth individual, for a total of ten examples (Individuals #112, #270, #412, #286, #413, #167, #160, #45, #258, #318). o If not current with vaccination schedule, indicate the clinical rationale for not following CDC guidelines for immunization. • Facility's policy for vaccination and immunization. The Facility provided documentation indicating that it did not maintain a Facility policy or procedure for its immunization and vaccination process and was recommended by the State Supported Living Center Medical Coordinator to "go to the CDC website to obtain current immunization schedules". The Facility's medical director informed the Monitoring Team that it will develop a policy for immunization and vaccination, based on CDC guidelines. The following is a summary of the Monitoring Team review of vaccination, and immunization records for Individuals #112, #270, #412, #286, #413, #167, #160, #45, #258, #318: • The Facility did not consistently document lot numbers of vaccines, expiration dates, and site of administration. Zero out of ten examples (0%) demonstrated evidence of documenting lot numbers, and expiration dates. • The vaccination and immunization records were clearly documented in zero out of ten examples (0%). The Monitoring Team strongly recommends that the Facility adopt a CDC recommended immunization record format to maintain evidence of vaccination and immunization. • One out of ten examples (10%) demonstrated documented evidence of vaccination or immunization for measles, mumps and rubella. It was evident that either the full vaccination series was not given, or there was a failure in appropriately documenting evidence of MMR vaccination or immunization status.	

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		• Four of ten examples (40%) documented evidence of vaccination or immunization for polio. • Ten out of ten examples (100%) had influenza vaccine in 2012. • Six out of ten examples (60%) documented vaccination with TDap within the last ten years. Summary: The Facility must enhance its immunization program by ensure strict adherence to CDC guidelines for immunization and vaccination. It would be advantageous for the Facility to ensure that there is clinically appropriate documentation for all recommended vaccinations, and follow CDC "catch up" recommendations, when necessary. The Monitoring Team also strongly recommends the Facility develop a policy and procedure for its immunization and vaccination practices that is consistent with CDC guidelines for vaccination, documentation, verification, and consent process for vaccination. <u>Cancer screening</u> The Monitoring Team assessed the Facility's ability to provide screening procedures for cancer by reviewing the Facility's screening process for mammography, colonoscopy, and PSA screening. Mammography: To assess the Facility's breast cancer screening process, the Monitoring Team reviewed: • List of all female individuals 40 years old, and older • List of all individuals who were current and not current with their annual mammogram screen • Documentation by the Facility indicating the rational why individuals were not current with their annual mammogram screen The Facility provided two distinct lists of individuals with the same title; "Mammogram". One list had three columns to indicate the individual's name, living area, and age. The second list include included columns for the individual's name, living area, age, date of mammogram only, reason if not up to date only, and comments. The Facility did not provide clear information for what these lists documented. The Monitoring Team was unable to interpret the information provided, and was therefore unable to determine the efficacy of the Facility's mammogram screening process. Colonoscopy: To assess the Facility's colon cancer screening process by means of colonoscopy, the Monitoring Team was provided the following documentation: • List of all individuals 50 years old and older	

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		• List of all individuals who were current with their screening colonoscopy • List of all individuals who were not current with their screening colonoscopy • Documented rationale for each individual not current with screening colonoscopy The Facility provided a list entitled "colonoscopy", that included the names of 103 individuals aged 50 or older, and a second list entitled "colonoscopy" that included the names of 66 individuals, along with the date that a screening colonoscopy was completed. There was no list documenting individuals who were not current with their screening colonoscopy, and rationale for not having a screening colonoscopy completed. Because the information requested was not made available, the Monitoring Team could not determine the efficacy of the Facility's colon cancer screening program. Prostate cancer screening by PSA blood test: The Monitoring Team reviewed the following documents to assess the Facility's prostate cancer screening program, by means of PSA blood testing: • List of all men age 50 and older • For the last ten individuals on the list: o Copy of their PSA test results o Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing o Rationale why annual PSA testing was not completed The Monitoring Team noted that the document provided, as part of the document request for PSA screening, included many copies of IRRFs that were irrelevant to the document request. Of the ten examples reviewed, ten out of ten (100%) indicated that annual PSA testing was completed. There was no evidence provided demonstrating the Facility's discussion with the LAR about the potential risks, benefits, and alternative to PSA testing. Acceptable standard of care practice dictates that the LAR be informed of the risks, benefits, and alternatives to PSA testing. The Monitoring Team compliments the Facility for ensuring PSA screening; however, the Facility must ensure that prostate cancer screening be discussed with the LAR, and that potential risks, benefits, and alternative to PSA screening were discussed. <u>Follow-up to acute medical conditions</u> To assess the Facility's ability to manage acute medical conditions, the Monitoring Team requested for review the following documents for the first reported acute medical	

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		condition that occurred during the week of June 3, 2013, for each medical provider: • Copy of all medical provider's IPNs, specific to the initial evaluation, and all subsequent follow-up IPNs through full resolution of the acute medical condition • Copy of all related diagnostics specific to the evaluation, and follow-up of the acute medical condition • All related consultation reports specific to the management of the acute medical condition The Facility provided documentation that there were no instances of acute medical conditions during the week of June 3, 2013. Summary: The Monitoring Team will discuss acute care issues with the Facility's medical director at subsequent reviews, to ensure examples are provided for review. <u>Clinical Management of Chronic Care Conditions</u> To assess the Facility's ability to manage chronic care conditions, the Monitoring Team requested lists of all individuals with the following three chronic medical conditions: Diabetes mellitus, osteoarthritis, and hypertension; and for the first three individuals on the list for each category, the following documentation: • Medical provider's IPNs, specific for evaluation of the chronic care condition, during the past six month review period. • Most recent IRRF • Past 12 months clinical consultations, specific to the chronic care condition. • Any diagnostics, including labs, and imaging studies, specific to the management of the chronic care condition, for the past 12 months. The Facility did not provide a list of all individuals with diabetes, but lists for hypertension, and osteoarthritis were provided. The Facility reported that 11 individuals had a diagnosis of osteoarthritis. Based on the age and physical disabilities at the Facility, the Monitoring Team is concerned that the Facility maybe under diagnosing osteoarthritis. A total of 29 individuals were reported to have a diagnosis of hypertension. Review of the clinical documents for individuals with either hypertension, diabetes, or osteoarthritis (Individuals #206, #286, #187, #75, #206, #337, #38, #568, and #243) indicated: • Four out of nine examples (44%) indicated specific, and clinically rational, risk assessment on the most recent IRRF.	

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		• Two of nine examples (22%) included medical provider IPNs indicating routine follow-up of the chronic medical condition. o Individuals #568, and #243 were followed, outside of the annual medical assessment, for the management of their diabetes mellitus. Documentation indicated improved follow up and care. o Individual #286 was seen by the medical provider for an acute exacerbation of the chronic medical conditions, but there was no evidence to support routine assessments, outside of the annual medical assessment. • For the three examples provided with diabetes: o Two out of the three examples (33%) included evidence of having had clinically appropriate screening labs: ▪ Individual #568 did not have evidence to indicate that microalbumin was assessed. Summary: The Monitoring Team strongly recommends that the Facility ensure that all chronic care conditions are identified and well documented, such as for osteoarthritis. Medical providers should periodically assess individuals for their chronic medical conditions, outside of the annual medical assessment. <u>Review of the Facility's clinical management of pneumonia</u> To assess the Facility's management of pneumonia, the Monitoring Team requested the following information: • Alpha list of all individuals who were diagnosed with pneumonia during the reporting period • Alpha list of all individuals who were diagnosed with recurrent pneumonia (more then three occurrences of pneumonia within the past five years) • For all individuals who experienced four or more cases of pneumonia with in the past five years: o Most recent annual medical summary o All quarterly physician reviews for the reporting period o Most recent IRRF o Most recent PT/OT assessment o Medical diagnostic, and consultation reports, specific to the management of pneumonia The Facility provided the Monitoring Team with three lists that were untitled; because the lists were not titled, and not fully completed, the Monitoring Team was unable to accurately determine if the lists were specifically for pneumonia infections, or all infections.	

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		The following is a summary of the Monitoring Team's findings from review of the documents related to the management of recurrent pneumonia: • Zero out five examples (0%) indicated a specific and clinically appropriate action plan for recurrent pneumonia. • Zero out of five examples (0%) included a habilitation plan that indicated a comprehensive clinical assessment, along with specific recommendations to help mitigate recurrent pneumonia. o The example for Individual #305 documented a comprehensive review of the pulmonologist's and gastroenterologist's consultation reports; however, the habilitation assessment did not document all necessary supports and services, or provide clinically relevant recommendations. • For two out of five examples (40%), the annual medical summary documented recurrent aspiration on the active problem list. • For zero out of five examples (0%), the annual medical summary documented a specific and clinically comprehensive action plan to help mitigate episodes of pneumonia. Within the context of a developmental disability setting, it is incumbent for the medical provider to regularly assess the efficacy of all prescribed supports and services. Medical providers should periodically observe tube feedings and other supports for feeding, physical transfers, and positioning of individuals on their caseload. • There were zero out of five examples (0%) demonstrating periodic assessment by the medical provider, specifically addressing recurrent pneumonia. o The Monitoring Team was informed by the medical director that medical providers do not perform quarterly physical assessments; and there was no documentation to indicate that medical providers routinely assessed the Individual to ensure that all necessary supports and services were in place and efficacious in helping to mitigate episodes of pneumonia. Summary: Medical providers at the Facility should develop specific and comprehensive medical action plans, that detail all necessary supports and services required for the management of recurrent pneumonia, and should periodically assess individuals with known recurrent pneumonia to ensure that all prescribed supports and services are efficacious. <u>Medical Providers Participation in the Interdisciplinary Team Process (IDT)</u> The Monitoring Team attended a post hospital interdisciplinary team meeting for Individual #318, and an annual Individual support plan meeting (ISP) for Individual #58. The following is a summary of the Monitoring Teams observation of these two meetings:	

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		Post Hospital Interdisciplinary Team Meeting (IDT) for Individual #318: • The primary medical provider enabled the IDT with an excellent overview of the Individual's medical condition, hospital treatments, hospital course, and post hospital expectations. • The primary medical provider enabled the IDT with a detailed explanation of medical issues that required enhanced supports and services, including management of chronic pain associated with the procedure, would care management. • The IDT members questioned the medical provider specifically about medical triggers, level of activity, and activities of daily living, and meaningful recommendations were delineated by the medical provider. • The IDT commented on the Individual's level of comfort, and activities that appeared to manifest with discomfort, and made necessary changes to the PNMP. • The IDT discussed specific signs and symptoms of pain manifestations that would be monitored. • The Individual's IRRF was reassessed by the IDT. • The lead IDT member provided a recap of the meeting, and listed the new action steps developed for the Individual. Annual ISP Meeting for Individual #58: The draft annual ISP, which was used for the annual ISP meeting, was noted to be comprehensive, and reviewed all of the Individual's documented health care issues. The Medical provider was present for annual ISP meeting and provided clinical insight into the Individuals identified medical diagnosis. The nurse who participated at the ISP reviewed the current IRRF, and provided meaningful insight into the ratings for each condition reviewed. Summary: The Monitoring Team determined that the medical providers ensured that the IDT members were made well aware of the individual's clinical condition, and required services to support the Individual following the acute hospitalization, and at the annual IDT meeting. Conclusion: The Monitoring Team noted improved following up on the management of diabetes mellitus, and improvement with the medical provider's participation at IDT, and ISP meetings. The Facility had enhanced its medical examination rooms obtaining necessary clinical equipment, and examination tables. Also noted, was continued improvement with the morning debriefing meeting, which provides an effective process to help improve on continuity of care. The Monitoring Team concurs with the Facility's self-assessment, and determined non-compliance for Section L.1. The Facility must continue	

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		to enhance its clinical processes in the area of immunization, evaluation of DNR status, and following up on chronic clinical care issues.	
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.	Provision L.2 requires the Facility to develop and implement a process to assess the clinical performance of medical providers. To comply with Provision L.2, the Facility adopted the DADS medical provider quality assurance audit process, and conducted both an internal and external audit each quarter. The Monitoring Team also reviewed the Facility's mortality review process by reviewing death review summaries, and met with the mortality review committee members, including Dr. Brett. To assess the Facility's ability to conduct clinical performance audits, the Monitoring Team reviewed the following documentation: • All assessments, graphs, summaries, action plans, and quality assurance (QA) reports for Internal and external medical audits for round 7 • DADS Internal and external medical audit policy, undated, no number • Clinical pathway audits for round 7 <u>External medical review</u> A physician that was external to the Facility conducted round seven of the external medical reviews on 3/21/2013 through 5/23/2013. Specific clinical indicators assessed for this review included diabetes, osteoporosis, and pneumonia. The clinical records utilized for review were randomly selected by a computer software program. For round 7, there were five medical providers who participated with the essential and non-essential compliance audit, but only four medical providers participated with the medical management compliance audit. External audits were divided into three components: • Essential elements, which required a Facility determined score of 100% compliance, as a passing score • Medical elements, which required a Facility determined score of 100% compliance, as a passing score • Non-essential elements, which required a Facility determined score of 80% compliance, as a passing score The outcome of the external medical reviews for round seven was as follows: • One out of five medical providers (20%) received a score of 100% for essential elements. • Four out of five medical providers (100%) received a score of 80% or greater for non-essential elements. • Zero out of four medical providers (0%) received a score of 100% for medical management reviews. • For the three medical management reviews o Diabetes had a cumulative score of 62% for all four medical providers. o Osteoporosis had a cumulative score of 83% for all four medical	Noncompliance

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		providers. o Pneumonia had a cumulative score of 82% for all four medical providers. Review of the medical management questions assessed for osteoporosis, diabetes, and pneumonia, indicated there were no examples of questions to determine if the medical provider assessed for the underlying etiology of a medical condition, or the efficacy of supports, and services prescribed to help mitigate exacerbation. There were no questions to determine if specific treatment modalities employed by the provider were the most current acceptable professional standard treatment for the medical condition. The medical director provided a document indicating that the Facility conducts a meeting following each external, and internal audit with the medical staff, and reviews the outcome form each audit, with emphasis on deficiencies. The Facility provided a document indicating that the internal and external medical management audits for round 7 relied on three of the six medical management topics, developed by the DADS central office. The reported six medical management topics include: Aspiration, Constipation, Diabetes, Osteoporosis, Seizures, and UTIs. Round 7 medical management topics included: Pneumonia, Diabetes, and Osteoporosis. The Monitoring Team noted a discrepancy in the Facility's reporting of the six medical management topics developed by DADS and the three medical management topics utilized for round 7: The Facility reported that it was assessed for "pneumonia"; however, pneumonia was not listed as a medical management topic developed by DADS. The Monitoring Team questions whether DADS developed a seventh medical management topic, or if the medical management topic "aspiration", implies aspiration pneumonia. The Monitoring Team requested all related data, graphs, and reports specific to the development, implementation, and follow-up of action plans for the medical audits. The Facility did not provide the requested documents; hence, the Monitoring Team could not complete its assessment of the Facility's external medical audit process. <u>Internal medical reviews</u> Round seven of the internal medical reviews was conducted on 5/14/2013. Specific medical indicators assessed for this review included diabetes, osteoporosis, and pneumonia. The clinical records were randomly selected by a computer software program, and used for the review process. Five of the practicing medical providers at the Facility were assessed through the internal essential and non-essential audits; however, only four of five medical providers participated with the medical management audit process. Internal audit reviews were divided into three components:	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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Essential elements, which required a Facility determined score of 100% compliance, as a passing score
Medical elements, which required a Facility determined score of 100% compliance, as a passing score
Non-essential elements, which required a Facility determined score of 80% compliance, as a passing score

The outcome of the external medical reviews for round seven was as follows:

One out of four medical providers (25%) received a score of 100% for essential elements.
Four out of five medical providers (80%) received a score of 80% or greater for non-essential elements.
Zero out of four medical providers (0%) received a score of 100% for medical management reviews.
For the three medical management reviews

Diabetes had a cumulative score of 100% for all four medical providers.
Osteoporosis had a cumulative score of 65% for all five medical providers.
Pneumonia had a cumulative score of 64% for all five medical providers.

The medical director provided a document indicating the noted discrepancy between internal and external medical audits:
<table>
<tr><th>Medical Management Item</th><th>Internal Audit Score</th><th>External Audit Score</th></tr>
<tr><td>Diabetes</td><td>100%</td><td>62%</td></tr>
<tr><td>Osteoporosis</td><td>65%</td><td>83%</td></tr>
<tr><td>Pneumonia</td><td>64%</td><td>82%</td></tr>
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Following the medical director's review, it was determined that the discrepancies in the internal audits were because of "mistakes" made by the internal auditor.

The Monitoring Team requested all related data, graphs, and reports specific to the development, implementation, and follow-up of action plans for the medical audits. The Facility did not provide the requested documents; hence, the Monitoring Team could not complete its assessment of the Facility's external medical audit process.

Summary:
The Facility did not provide documentation specific to the development, implementation, and follow-up of action plans for this review, the Monitoring Team was unable to complete it's assessment of the Facility's process to assess the clinical performance of its medical providers. The Monitoring Team continues to be concerned with the low
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		number of medical management topics utilized for the medical audits; utilizing the same medical audit topics for other Facilities during the same medical audit round; and for not specifically assessing clinical performance of its medical providers. <u>Mortality review</u> The Facility had made no changes or revisions to their Administrative Death Review Committee, Policy: I.4.b and Clinical Death Review Committee, Policy: I.4.c since the last compliance review. The Monitoring Team met with Medical Director, Chief Executive Nurse, Quality Assurance Nurse, and Quality Assurance Director and reviewed/discussed the Facility's Death Review Policies and Processes, as well as death information provided for review, 10/10/13. State Office Nursing Coordinator observed the meeting. Since the compliance review, three deaths had occurred at the Facility. One death that occurred on 9/13/13 was not reviewed because the Administrative and Clinical Death Review Committees had not yet met to review the death. The outcome of the death review and recommendations will be reviewed at the next compliance review. Two deaths that occurred during the last compliance review, for which review was completed following that review, were reviewed in addition to the two deaths that had occurred since the last review and for which the reviews had been completed. The Monitoring Team's findings included: • Of the four deaths reviewed, the average age was 50.2 years (ages varied from 36 to 70 years of age). • Three of four (75%) deaths had conditions leading to deaths associated with aspiration pneumonia/pneumonia. There was concern regarding the high incidence of deaths associated with aspiration pneumonia/pneumonia, which was potentially preventable. • Four of four (100%) deaths had State of Texas Department of State Health Services – Vital Statistics Unit, Certificate of Deaths completed and available for review. The cause of individuals' deaths on the Certificate of Deaths are listed in the chart below: 1. Immediate cause of death: Gastrointestinal Hemorrhage Underlying cause of death: Aspiration 2. Immediate cause of death: Cardiopulmonary Arrest Significant condition contributing to death: Pneumonia Underlying causes of death: Recurrent Aspiration 3. Immediate cause of death: Chronic Lymphocytic Leukemia 4. Immediate cause of death: Cardiopulmonary Arrest Underlying causes of death: Hypoxic Respiratory Failure Significant conditions contributing to death: Aspiration	

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		The Monitoring Team's review of the death documents for compliance with the Facility's death review policies and processes found: • Two of four (50%) decedents resided in the Driscoll, respectively in Driscoll C and Driscoll D. One of four (25%) decedents resided in Childress A. One of four decedents (25%) resided in Cottage G. • Two of four (50%) decedents were enterally nourished. • Three of four (75%) decedents had Medical Histories/Chronic Diagnoses of aspiration and/or dysphagia. • Two of four (50%) deaths occurred in the hospital and two of four (50%) deaths occurred at the Facility. • Two of four (50%) deaths occurred at the Facility under hospice care. • Four of four (100%) decedents had Do Not Resuscitate (DNR) orders prior to and at the time of illness/incident and/or death. • Four of four (100%) decedents had DNR orders at the time of death. • Zero of four (0%) decedents had an autopsy performed • Four of four (100%) deaths had Unusual Incident Reports completed. • Four of four (100%) deaths had Quality Improvement Death Review of Nursing Services Reports completed by the Quality Assurance Nurse within five working days, per policy. • Three of four (75%) deaths were determined not unusual/natural. One of four (25%) was determined as an accident due to choking on thickened liquids. Heimlich maneuver performed was unsuccessful. Cardiopulmonary resuscitation (CPR) was initiated and 911 was called. Upon the arrival, the Emergency Medical Services personnel suctioned a copious amount of stomach contents. The Individual was transferred to the hospital where efforts to resuscitate were unsuccessful. • Three of four (75%) Death Discharge Summaries were completed by the attending physician within five working days, according to policy. One Death Discharge Summary (25%) was completed but was not dated; therefore, it could not be determined if it was completed within the specified timeline. • One of four (25%) of the Clinical Death Review Committee Meetings was conducted within 14 calendar days of notification of the deaths, although all Clinical Death Review Committee Meetings (100%) were completed after the due dates, per policy. • Three of four (75%) of Clinical Death Review Committee Meetings attendance signature sheets showed that external physicians participated. • Three of four (75%) Clinical Death Review Committee Meetings resulted in recommendations. However, the medical recommendation for one meeting was not stated in terms that could be measured and tracked. • Two of four (50%) Administrative Death Review Committee Meetings were conducted within 21 calendar days after receipt of the minutes from the Clinical	

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		Death Review Committee Meetings, although all Administrative Death Review Committee Meetings (100%) were completed after the due dates, per policy. • Two of four (50%) Administrative Death Review Committee Meetings resulted in recommendations. • Three of four (75%) deaths reviewed by the Administrative Death Review Committee contained documentation that the Facility Director submitted summaries of the resulting actions taken from the Clinical and/or Administrative Death Review Committee Meetings, as required within 28 calendar days following the Administrative Death Review Committee Meeting. Such documentation for one death was not provided for offsite review. Therefore, it could not be determined whether this information was summarized. • The Quality Assurance Nurse continued to: o Maintain a Death Review Tracking Sheet for each death indicating when the various timelines were due and completed for required components of the death review policies. o Conduct Quality Improvement Death Reviews of Nursing Services Reports for each death and make appropriate recommendations for nursing services. Recommendations were primarily directed to the nursing staff. o Maintain Death Review Tracking Sheet for recommendations through to resolution, as well as for ongoing recommendations. ▪ Three of three (100%) deaths that had clinical and/or administrative recommendations were carried out through to resolution or were ongoing. Summary: The Quality Assurance Nurse continued to track compliance with the Facility's death review polices, including tracking recommendations resulting from the URIs and Quality Improvement Death Review of Nursing Services. As was found at the last compliance review, the nursing recommendations resulting from these reviews were relevant; they were not included as recommendations in the Clinical and/or Administrative Death Review Committee Reports. Few medical recommendations were included in the Clinical and/or Administrative Death Review Committee Reports. The recommendations made by Medical Director were not stated in terms that could be measured and tracked. This concern was discussed with the staff. The Medical Director agreed to state recommendations in terms that are measurable; for which the data can be tracked, analyzed, and trended over time in order to make systemic improvements in the death review process. The Monitoring Team will follow-up on this issue at the next compliance review. The Monitoring Team has significant concern over the number of pulmonary related deaths at the Facility. During its review of three cases of pneumonia, as delineated in	

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		Provision L1 of this report, the Monitoring Team noted that the Facility did not assertively assess individuals for recurrent pneumonia, and as per Provision O4, maladaptive position and lack of implementation of physical and nutritional management plans remain problematic at the Facility. The etiology of causes of aspiration, choking, and recurrent pneumonia must be assertively assessed, and provide definitive treatment when clinically appropriate. Furthermore, the Facility must enhance positioning, feeding, and gastrointestinal tube feeding practices. Since the last review, there had been no significant improvements found in the Facility's overall death review process. The requirements for completing various timelines for components of the death review policies were inconsistently met. The reason for the Facility to conduct death reviews was to ensure thorough, systemic, and integrated death reviews were conducted in order to develop recommendations to improve health care. Additionally, contrary to other State Support Living Centers, the Facility's policy designated the Medical Director to chair the Administrative Death Review Committee Meeting as opposed to the Facility Director. The Facility had not conducted a Mortality/Morbidity Review and Analysis of longitudinal data related to deaths in order to track and trend systemic issues, develop corrective action plans, or the efficacy of the corrective actions. The Medical and Nursing Departments, as well as the Quality Assurance Department should develop a list of critical questions to answer in reviewing each decedent's medical record. This could further improve the scope and depth of clinical discussions and recommendations, in addition to providing consistency among the reviewers. According to an onsite discussion with the State Office Nursing Coordinator, she related that the State was still in the process of revising the Death Review Policy. When the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care. The Medical Department did not provide a meaningful clinical review of each death that would enable comprehensive insight into the clinical care of the individual. It is essential that a root cause analysis of each death be completed. Conclusion: The Monitor Team compliments the Facility for conducting the external medical provider quality assurance audits; however, the Monitoring Team was unable to complete its assessment of the medical audit process because documents requested for the Facility's development, implementation and follow-up for action plans were not provided. The	

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		Monitoring Team recommends that the medical audit process be revised to reflect an assessment of clinical performance, by assessing medical providers practice standards as compared to generally accepted standard of care practice. The mortality review process must be significantly revised to ensure that medical providers conduct a comprehensive case review of all death, and that meaningful recommendations are provided for each death, derived by a root cause analysis. The Facility must conducted periodic analysis of all deaths. When the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care. The Monitoring Team strongly recommends that all mortality reviews include a comprehensive review of clinical care, with the goal of identifying strategies to enhance the delivery of medical care at the Facility, and not focus on the immediate circumstance surrounding the death.	
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.	Provision L3 requires the Facility to implement a quality assurance (QA) process for medical services. To assess the Facility's effort towards compliance for Provision L3, the Monitoring Team requested the following documentation: 1. Policy and procedure specific to a medical quality assurance process/program at the Facility 2. Copy of all medical indicators used for medical QA 3. Copy of data, graphs, data analysis, and past six months of committee meeting minutes, specific to medical QA process 4. Copy of all recommendations (action plans) by medical QA committee to enhance medical outcomes at the Facility; also include evidence to support that the action plans were implemented, and followed up on for completion and efficacy The medical director informed the Monitoring Team that it had not developed a medical quality assurance process, and there were no documents provided to support the development of a medical QA process, but is in the process of doing so; in fact, the Facility had developed several clinical data tracking sheets for cerebral palsy and degenerative spine disease, that will be implemented in the near future. Conclusion: Because the Facility had not developed, a data-driven process to track, and trend medical outcome indicators, for the purpose of enhancing clinical care at the Facility, the Monitoring Team determined noncompliance with Section L.3. The Facility must develop and implement a medical quality assurance process that tracks and trends positive outcomes and adverse outcome for its medical practices. Furthermore, the process must include a mechanism for the development and follow-up of remediation efforts for all identified adverse outcomes and deficiencies.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	Provision L.4 requires that the Facility maintain appropriate policies and procedures to ensure quality medical services at the Facility. To assess compliance for Provision L.4, the Monitoring Team reviewed the Facility's self-assessment, and discussed efforts with the Facility's medical director. The Monitoring Team met with the medical director to discuss the Facility's development and implementation of policies and procedures for its medical practice. The Monitoring Team was informed that the Facility had yet to develop all of the necessary local policies and procedures for its practices. The Monitoring Team noted that the Facility did not have specific policies or procedures for many of the medical practices. For example, the Facility did not have a current, policy or procedure to delineate its specific process for mortality review, medical quality assurance process. or immunization and vaccination process. The Monitoring Team was informed by the medical director that the DADS central office had developed, and provided them with a draft version of a central Medical Care Policy, which was dated 10/2/2013. The Monitoring Team reviewed the policy and noted that it is generalized, and affords the Facility a guideline of expectations set forth by the central office; however, the policy does not delineate the necessary efforts required by the Facility to ensure follow-through by relevant staff. For example: • The Policy indicates that "all individuals receive current immunizations according to the recommendations made by the Advisory Committee for Immunization Practices, unless otherwise indicated", and "A PCP enters the individual's immunization status in the Preventative Care Flow Sheet", but no specific procedural outline for this practice: o The Facility must maintain a current procedure that clearly delineates the specific vaccines provided to individuals; vaccine schedule; assessing for immunity, when clinically appropriate; and specific documentation for immunization, that adopts the CDC recommendations on documenting immunization status. The CDC makes many recommendations for vaccination, and immunization; however, the medical providers at the Facility must be made aware, by means of a current procedure, on what specific vaccination must be provided to the Individual. • The policy did not specific minimum expectations for follow-up on acute and chronic conditions. The Facility must ensure that such follow-up meets, or exceeds, minimal standard of care practice; hence, medical providers must be made aware of the Facility's expectation for follow-up through resolution for acute medication conditions, and regular assessment of known chronic medical conditions.	Noncompliance

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		• For aspiration pneumonia, the policy indicated that "antibiotics must be used appropriately", but did not provide specific information for the medical provider to ensure appropriate use of antibiotics. For example, each Facility must have its own biogram data that indicates the effectiveness of antimicrobial agents, and resistance pattern of organisms common to that Facility. o Medical providers must be made aware to rely on the current biogram data, and other specific recommendations necessary for the treatment of infections at the Facility; hence, the Facility must ensure a procedure for medical providers to follow, specific to the utilization of antimicrobials at the Facility. Conclusion: Because the Facility did not develop or maintain necessary policies and procedures delineating its clinical practices, the Monitoring Team determined that the Facility is noncompliant with Section L.4. The Facility must develop, and implement functional policies, and procedures to enable medical providers, and other relevant staff, specific guidance on the Facility's practice standards of care.	

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:** 1. BSSLC Section M Self-Assessment, updated: 9/23/13 2. BSSLC Section M Action Plan, updated: 9/19/13 3. BSSLC Section M Presentation Book 4. Department of Aging and Disability Services (DADS) Infection Control Committee Guidelines, May 2013 5. DADS Policy 010.3, Nursing Services, 6/17/13 6. DADS Guidelines: Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, April 2013 7. DADS Infection Control Committee Guidelines, May 2013 8. DADS Procedure: Guidelines for Prevention and Monitoring of Clostridium difficile Infections, July 2013 9. DADS Procedure: Medication Administration Observation Guidelines (draft), June 2013 10. Texas Department of Health Services, Texas Notifiable Conditions, January 2013 11. BSSLC Policy N.9 Pharmacy Services and Safe Medication Practices, Quarterly Drug Regimen Reviews 7/1/13 12. BSSLC Policy N.12 Pharmacy Services and Safe Medication Practices, Medication Variances 6/5/13 13. BSSLC Policy N.13 Pharmacy Services and Safe Medication Practices, Destruction of PHI Material 6/5/13 14. BSSLC Emergency Response Committee Meeting Procedure 15. BSSLC Isolation Procedure/Notification Guidelines/Isolation Audit Tool, 9/5/13 16. BSSLC Declination of Influenza Vaccine Form 17. BSSLC Infection Control Manual, 4/12/13 18. BSSLC Guide to Preventing Clostridium difficile Infections, APIC Implementation Guidelines, 2013 19. Brenham SSLC Guidelines: Nursing Required Training Topics and Training Materials for New Nurse Orientation and Annual Refresher Training, 7/26/13 20. BSSLC Nursing Organizational Chart 21. BSSLC Nursing Education Department Update, April 2013 through October 2013 22. BSSLC Full Time Nursing Positions and Unfilled Positions 23. BSSLC Nursing Minimum Staffing Report, April 2013 through August 2013 24. BSSLC Nursing Staffing Analysis Report, March 2013 through August 2013 25. BSSLC Current RN Case Managers' Caseloads 26. BSSLC Current Nursing Ratios for Direct Nursing Staff 27. BSSLC Current Nursing Ratios for RN Case Managers 28. BSSLC Nursing Overtime Hours by Shift for Last Six Months 29. BSSLC Summary of Contract Nursing Hours, by Shift for Last Six Months 30. BSSLC Nursing Meeting Schedules for the Week of October 6, 2013 31. BSSLC Summary of Nursing Training Data for Last Six Months 32. BSSLC Nursing Managers Meeting Minutes, 4/13/13, 4/24/13, 6/18/13, and 8/21/13 33. BSSLC Nurse Managers/Nursing Administration Meeting Minutes, 6/6/13 34. BSSLC Nursing Administration Meeting Minutes, 8/20/13

	35. Collaborative Meetings between BSSLC and Scott and White-Brenham Hospital minute summaries, March 2013 through September 2013 36. BSSLC Nursing/Quality Assurance Audit Tool Meeting Minutes, 7/22/13 37. BSSLC Cardiopulmonary Resuscitation (CPR) Emergency Response Committee Meeting Minutes, 4/11/13 and 7/11/13 38. BSSLC Summary of Emergency Medical Equipment and Automated External Defibrillators (AEDs) Checklist for the Last Six months 39. BSSLC List of Location for Emergency Medical Equipment and AEDs 40. BSSLC List of Staff Responsible for Conducting Mock Medical Emergency Drills 41. BSSLC CPR and Mock Medical Emergency Drills Data for Last Six Months 42. BSSLC Completed Mock Medical Emergency Drill Checklists for Last Six Months 43. BSSLC Antibiogram Report, 9/10/13 44. BSSLC List of Employees Due/Delinquent for Infection Control Training Refresher, 9/9/13 45. BSSLC Infection Control Committee Meeting Minutes, 5/30/13 and 8/29/13 46. BSSLC Infection Control Round Reports, March 2013 through August 2013 47. BSSLC Infection Control Meeting Minutes with the CNE, RN Case Manager, and Compliance Nurse, 4/2/13, 6/6/13, 6/21/13, and 8/19/13 48. BSSLC Infection Control Nurse Duties 49. BSSLC RN Case Manager Supervisor/Settlement Agreement Meeting Minutes with the CNE and Compliance Nurse, 5/22/13, 6/25/13, and 8/19/13 50. BSSLC Health Compliance Team Meeting Minutes, 5/14/13, 5/22/13, 7/26/13, and 8/21/13 51. BSSLC Nurse Educators/Settlement Agreement Meeting Minutes with CNE and Compliance Nurse, 6/15/13, 6/25/13, and 8/19/13 52. BSSLC Percentage of Individuals Current with Tuberculosis (TB) Screenings 53. BSSLC Percentage of Individuals Current with Influenza Vaccinations 54. BSSLC Percentage of Employees Current with TB Screenings 55. BSSLC Percentage of Employees Current with Influenza Vaccinations 56. BSSLC Percentage of Employees Current with Hepatitis B Vaccination Series 57. BSSLC Infection Control Monitoring Procedures and Tools 58. BSSLC Shigellosis Training Material and Training Rosters 59. BSSLC Review of Urinary Tract Infections 60. BSSLC Antibiogram, 6/1//12 through 2/28/13 61. BSSLC "Real Time" Audit Tool for Acute Infections and Instructions, 6/7/13 62. BSSLC Acute Care Plans Training, 8/8/13 63. BSSLC Infection Control Tracking Data, April 2013 through August 2013 64. BSSLC Tuberculosis Screening Report, 10/10/13 65. BSSLC Immunization Database, 10/10/13 66. BSSLC Skin Integrity Quarterly Committee Meeting Minutes, 4/24/13 and 7/24/13 67. BSSLC Nursing and QA Nursing Medication Administration Audit Procedures 68. BSSLC Training Medication Administration Monitoring Tool Summary Data March 2013 through July 2013 69. BSSLC Monthly Medication Variance Data for last six months

	70. BSSLC Monthly Medication Variance Committee Meeting Minutes for last six months 71. BSSLC Quarterly Pharmacy and Therapeutic Committee Meeting Minutes for Last six months 72. Review of ten of the most recently completed Medication Variance Reports for Individuals #205, #490, #34, #570 (two medication variances), #243, #248, #536, #75, and #400 73. Review of seven recently and/or currently hospitalized included Individuals #61, #269, #305, #59, #88, #332, and #318 74. Review of three active pressure ulcers included Individuals #332, #88, and #38 75. Review of 18 cases of reportable communicable diseases included Individuals #411, #539, #332 (three cases), #37, #264, #582, #247, #132, #51, #523, #193 #191, #33, #412, #226, and #50 76. Review of four recently and/or currently active Urinary Tract Infections for Individuals #19, #160, #481, and #88 77. Review of a sample of 12 most recently completed Admission, Annual and/or Quarterly Nursing Assessments selected from the Facility's At Risk List for individuals identified at high/medium risk health conditions from each unit for Individuals #151, #258, #413, #591, #251, #384, #215, #167, #96, #490, #263, and #86 **People Interviewed:** 1. Valerie Kipfer, RN, MSN, State Office Nursing Coordinator 2. Debra Williams, RN, Chief Nurse Executive (CNE) 3. Tammy Pavlu, Nursing Operations Officer (NOO) 4. Joy Sorensen, RN, RN Case Manager Supervisor 5. Jill Quimby, RN, Quality Assurance (QA) Nurse 6. Doris Poston, Nurse Educator 7. Joanne Guard, RN, Infection Control Nurse 8. Kellie Fitch, RN, Hospital Liaison Nurse 9. Leona Sian, RN, RN Shift Manager/Durable Medical Equipment Nurse 10. Judy Blain, RN, Nurse Manager, Cottages Estates and Childress Terrance 11. Stephanie Hintzel, RN, Nurse Manager, Driscoll Gardens 12. Jane Barnett, RN, Nurse Manager, Bowie Springs 13. Susan Fletcher, Lead RN Case Manager, Fannin Villa 14. Numerous Staff Nurses 15. Daniel Dickson, QA Director 16. Robin Blankenburg, RPh, Director of Pharmacy 17. Mary Anne Brett, M.D., Medical Director 18. Shirley Kwiatkowski, Food Services Manager **Meeting Attended/Observations:** 1. Meeting with Nursing Administration/Leadership to Review Section M Presentation Book, 10/7/13 2. Toured Childress, Fannin B and C, and Inspected Emergency Equipment and Medication Rooms, and toured Driscoll Treatment Room. 3. Conducted Medication Administration Observations in Childress A and C, 10/7/13 4. Medical Morning Meeting, 10/8/13 and 10/9/13 5. Toured Main Kitchen, 10/8/13 6. Inspected Cottage B Emergency Equipment and Medication Room and Conducted Medication

	Administration Observations in Cottage B, 10/8/13 7. Facility Death Review Meeting, 10/9/13 8. Medication Variance Review Meeting, 10/9/13 9. Nurse Manager Meeting (included QA Nurse), 10/9/13 10. Toured Bowie, Inspected Emergency Equipment and Medication Room in Bowie A, Toured Treatment Room, and Conducted Medication Administration Observations in Bowie A, B, and E, 10/9/13 11. Post-Hospitalization ISPA Meeting for Individual #318, 10/10/13 12. Pharmacy and Therapeutics Meetings, 10/10/13 13. Impromptu Mock Medical Emergency Drill in Driscoll, 10/10/13
	Facility Self-Assessment: For Section M, in conducting its self-assessment, the Facility: • Used the statewide Facility Self-Assessment Monitoring Tools. The monitoring/audit tools the Facility used to conduct its self-assessment included: Nursing Care Monitoring Tools and Nursing Protocol Audit Tools, Medication Room Audit Tool, Medication Administration Record Audit Tool, and Medication Administration Observations Audit Tool. • These monitoring/audit tools included sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. • The monitoring tools included sufficient methodologies, such as observations, interviews, record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number for percent of sample size of individuals/records as compared to the overall population was not included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was provided by months, quarters, and overall percentage of compliance. Although this information was not provided, the Facility had a formalized procedure for conducting monitoring and/or observing each tool. • The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing the audit tools: The Chief Nurse Executive, served as the lead for the section. The Nursing Operations Officer reviews all of the completed audit data completed by the RN Nurse Case Managers Infection Control Nurse, and Hospital Liaison Nurse. The Quality Assurance Nurse performed inter-rater reliability checks on the audits completed by the Nursing Department. • The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were programmatically competent in nursing. • Sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. • The Facility used other relevant data sources and/or key indicators and/or outcome measures. For example, these included databases that showed the percentage of compliance with assessments, percent of nurses who had completed training classes, and number of pressure ulcers.

	• The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment, Presentation Book, and Action Plans: o Presented findings consistently based on specific, measurable indicators. The data provided an indication of the areas of strength, weakness, or the status of progress. The indicators clearly identified what was being measured or the criteria used for measurement. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the Nursing Department. The Facility's Self-Assessment stated they were not in compliance with Provisions M.5 but were in substantial compliance with Provisions M.1, M.2, M.3, M.4, and M.6; the Monitoring Team did not concur with their findings of substantial compliance with Provisions M.1 and M.3, but agreed with substantial compliance with Provisions M.2, M.4, and M.6 and noncompliance for Provision M.5.
	Summary of Monitor's Assessment: Based on the Monitoring Team's review, Provisions M.2, M.4, and M.6 were found in substantial compliance. Provisions M.1, M.3 and M.5 were not found in substantial compliance. The Nursing Department showed significant progress in Section M Provisions, except Provision M.5, which is closely aligned with compliance with the Integrated Risk Rating and IHCP processes. Provision M.1 contained multiple requirements. If the requirements for staffing, Hospital Liaison Nurses, Infection Control, and Emergency Response System were standalone activities they would be considered in substantial compliance. Recently a new Nurse Educator/Skin Integrity Nurse was hired who was previously certified in wound care nurse. She was in the process of becoming recertified. She was in the process of reviewing pressure ulcer data and improving the tracking and trending of data in an effort to make improvements. The Facility continued to have a high incidence of pressure ulcers. It is not solely the Skin Integrity Nurse's responsibility for reducing/preventing pressure ulcers. The Facility needs to adopt a zero policy for pressure ulcers. The Facility needs to become more proactive and ensure that all relative disciplines work collaboratively to reduce/prevent pressure ulcers. The Quality Assurance processes are well established, including inter-rater reliability processes. Provision M.2 showed that the Nursing Department had fully implemented the revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. The RN Case Manager Supervisor had put forth concerted effort in training the RM Case Managers and reviewing the completed Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessments. This Provision continued to be in substantial compliance. Provisions M.3 showed that the RN Case Manager Supervisor had put forth concerted effort in training the RN Case Managers and reviewing the completed Acute Care Plans. As a result the plans were exemplary. They showed significant improvement in the individualization, comprehensiveness, and quality of the plan. There was also improvement in IHCPs, which met most criteria, except that action plans for nursing interventions need to contain more specificity as to what is monitored and documents. This Provision was not yet in substantial compliance, but significant progress had been made.

	Provision M.4 continued to show a robust competency based educational program that tracked all required training and ensured the training was completed. There was evidence through interviews with nursing administration and management staff, and individuals' records reviewed, that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficient to meet individuals' health care needs. This Provision continued to be in substantial compliance. Provision M.5 showed the Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. These processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance. The RN Case Manager Supervisor had put forth concerted effort in training the RN Case Managers in moving these provisions forward toward substantial compliance. This Provision was not found in substantial compliance. Provision M.6 continued to show significant progress in all aspects of medication administration practice according to current generally accepted standards of practice. The Facility had a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances. This Provision continued to be in substantial compliance.

#	Provision	Assessment of Status	Compliance
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.	<u>Monitoring Team Findings</u> The Monitoring Team validated the information presented in the Facility's Self-Assessment through: Review of the information presented in Provision M.1's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Nurse Educator/skin Integrity Nurse, QA Nurse, Hospital Liaison Nurse, RN Case Manager Supervisor, and Nurse Managers; review of individuals' records, and observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.1. The Monitoring Team did not concur with their findings. This Provision of the Settlement Agreement requires the Facility to address various areas of compliance in order to meet substantial compliance with this Provision. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2, M.3, and M.5 of the report. Information and recommendations regarding nursing documentation on restraint usage is included above in Provision C.5 of the report. Information and recommendations regarding nursing documentation for the death review process is reported above in Provision L.2. <u>Staffing:</u> • At the time of the compliance review, the Facility census was 288. At the time of the compliance	Noncompliance

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		review, the Facility had a total of 118.5 budgeted nursing positions, which remained unchanged from the last compliance visit. There was a total of 109.5 filled nursing positions and a total of nine unfilled nursing position, of which 63.5 RN positions and 46 LVN positions were filled, with four unfilled RN positions and five LVN unfilled positions. • The Nursing Department continued to maintain a stable and highly dedicated and motivated staff. Since the last compliance review, the Nursing Operations Officer had resigned and was replace by an incumbent Nurse Manager. The Assistant Nurse Educator assumed the Nurse Manager position for the Childress and Cottages units that was previously filled by the Nurse Manager who was promoted to the Nursing Operation Officer. It was positive to find that the Nursing Department developed incumbent nurses to take on higher levels of responsibility. Promoting incumbent nurses to higher levels of responsibility prevents downtime in the learning curve, as well as having nurses who know the individuals. The Nurse Educator position that was filled also served as the Skin Integrity Nurse. This nurse was a certified wound care specialist. • As found in previous compliance reviews, the Nursing Department's Administrative and Management staff continued to have a robust and effective method of monitoring and analyzing staffing patterns daily, monthly, and longitudinally on each unit/cottage for each shift. This was accomplished by having a dedicated staffing coordinator who reviewed the schedule several times during the day, filling shifts as call-ins occurred, and kept the all Nurse Manager and other related staff informed. After hours, weekends and holiday shifts were maintained by the RN Shift Managers, who reviewed the schedule and filled open shifts as they occurred. The Nurse Managers and/or Administrative Nurses take rotations of being on call and come in to fill any needs on the campus. The Nursing Department's scheduling, monitoring and analyzing system was exemplary to peer State Supported Living Services (SSLC) Nursing Departments. The CNE stated their system was shared with other SSLC CNEs, of which some plan to visit BSSLC and review their system. • For the past six months the established staffing ratios were met for all units/cottages and all shifts. The current turnover rate reported for all nursing was 16.03% (unit nurses 17.72% and professional staff 12.65%) based on the last six months average. This showed an overall decrease in turnover rates, which was 25.3% at the last compliance review. The Nursing Department's analyses of the reasons for nursing turnover found nurses desire to be closer to home, to return to school, or were terminated. The Nursing Department continued ongoing efforts to recruit, maintain, and evaluate reallocations of nursing position sufficient to meet the Facility's requirement to provide all aspects of nursing services. In May 2013, BSSLC's recruitment efforts included posting open nursing positions in small town newspapers, which received significant response. In addition, an out of state nurse was hired, who subsequently recruited eight additional nurses. Several of the recently hired LVNs were recent graduates. It was positive to find that in an effort to enhance recent graduates nursing knowledge, skills, and competency, the Nursing Department had implemented a preceptor program by assigning an experienced nurse to each of the recent graduates to assist them through the learning curve. • Agency nurses continued to supplement staffing when full time nurses were on extended leave	

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		and/or during vacations. Most of the agency nurses had worked at the Facility for an extended period of time and were well acquainted with the individuals. The agency nurses continued to receive the same nursing orientation and refresher training as the full time nurses. The RN Shift Manager/Durable Medical Equipment Nurse was responsible for overseeing the competency of the agency nurses and for providing additional training when required, particularly related to medication administration and efforts to mitigate medication variances. Based on a review of nursing staffing documentation and interview with the CNE, the Facility appeared to have a sufficient number of nursing staff to meet individuals' health care needs. <u>Quality Assurance Efforts:</u> Since the last compliance review, the Monitoring Team found there was a continued effort to make improvements in the monitoring procedures, which included: • The SSLC Nursing Department now selects which of the Protocol Card Audit Tools and Nursing Care Monitoring Tools that they wish to use for auditing/monitoring based on their individual needs identified to improve nursing services. Listed below are the processes and auditing/monitoring tools selected by the BSSLC Nursing Department: o <u>Audit Tools Related to the Protocol Cards:</u> ▪ Elevated Temperatures: Monthly Nurse Managers audits five or 10% if that is more than five, or all of the incidences if there are fewer than five of elevated temperatures on their homes. ▪ Seizures: Monthly the QA Department provides the sample from the high risk database and gives it to the NOO for distribution to the Nurse Managers. Two audits were completed per home, except for the Cottages, which completes three audits. ▪ Urinary Tract Infection (UTI): Twice a month Pharmacy provides Nursing Administration a list of individuals on antibiotics for UTI. The QA Department pulls all UTIs from this list and forwards to the NOO, who then distributes the list to the appropriate Nurse Manager(s). ▪ Pre-Treatment/Post-Sedation: The Compliance Nurse completes five audits per month or all, depending on which was the lower number. Elevated Temperature and Pre-Treatment/Post-Sedation audits were completed monthly, but tracked and trended on a quarterly basis. Seizure and UTI audits were completed and tracked and trended on a monthly basis. • Nursing Care Plans: The QA Department sent the RN Case Manager Supervisor a sample of five UTIs diagnosed for the month. The RN Case Manager Supervisor or designee completed the Nursing Care Plan Audits. • Urgent/ER/Hospitalization: The QA Department pulled the samples and the audits were completed by the Hospital Liaison Nurse. Two audits were completed per home, except for the Cottages, which completed three audits.	

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Infection Control: The QA Department pulled the samples and the audits were completed by the Infection Control Nurse. Three audits were completed for Unit 1, three audits for Unit 2, and three audits for Unit 3.
According to the Facility Self-Assessment, quarterly meetings minutes conducted by the CNE, NOO, Compliance Nurse, QA Nurse, and QA Director showed efforts were made to improve:

Monitoring tools used, which included items on the tools that were not found useful.
Data reports prepared by the Data Analyst and presented to the QA/QI Council to track, trend, and analyze monitoring data from the past three months to determine if systemic issues were identified for monitoring results falling below 80%. If systemic issues were identified, the CNE, NOO, Nurse Educator, Compliance Nurse and QA Nurse met quarterly to develop, implement, and complete plans of corrections campus-wide. If monitoring issues were not systemic, local issues were identified for monitoring results falling below 80%; the results were forwarded to the appropriated Nurse Manager for corrective action. In addition to the quarterly meetings, the QA Nurse attended the weekly Nurse Manager Meetings due to the inconsistencies identified relating to inter-rater reliability checks of the audit/monitoring tool results. The meetings discussed and resolved each question on the audit/monitoring tools to provide clarification on how the results of the audit/monitoring tools were rated.

The Monitoring Team's review of the QA/QI Council Report, September 25, 2013, for nursing's overall audited/monitored data, aggregated by unit, for May 2013 through July 2013 is represented in the chart below. The data for August and September 2013 were not yet available for review.

<table>
<tr><th>Nursing Audit/Monitoring Tools</th><th>Unit 1</th><th>Unit 2</th><th>Unit 3</th><th>Overall Average</th></tr>
<tr><td>Annual Nursing Assessment</td><td>86%</td><td>91%</td><td>97%</td><td>90%</td></tr>
<tr><td>Infection Control</td><td>80%</td><td>88%</td><td>89%</td><td>86%</td></tr>
<tr><td>Seizure Management</td><td>93%</td><td>46%</td><td>87%</td><td>84%</td></tr>
<tr><td>Urgent Care/ER/Hospitalization</td><td>83%</td><td>83%</td><td>84%</td><td>83%</td></tr>
<tr><td>Urinary Tract Infection</td><td>64%</td><td>42%</td><td>25%</td><td>59%</td></tr>
<tr><td>Averages</td><td>81%</td><td>70%</td><td>77%</td><td>80%</td></tr>
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The Monitoring Team's review of the QA/QI Council Report, September 25, 2013, QA Nurse Auditor's inter-rater reliability level of agreement May 2013 through June 2013 is represented in the chart below. The data for August and September 2013 were not yet available for review.

<table>
<tr><th>Nursing Audit/Monitoring Tools</th><th>May 2013</th><th>June 2013</th><th>July 2013</th></tr>
<tr><td>Urgent Care/ER/Hospitalization</td><td>92%</td><td>75%</td><td>92%</td></tr>
<tr><td>Annual Nursing Assessment</td><td>94%</td><td>89%</td><td>N/A</td></tr>
<tr><td>Infection Control</td><td>79%</td><td>84%</td><td>100%</td></tr>
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Seizure Management	82%	73%	100%
Urinary Tract Infection	55	73%	38%

The audit/monitoring process described above appears promising. Although an overall percentage of compliance was derived, it should not be used as a true measurement of overall compliance; since it was noted in the previous review that the percentage for Urinary Tract Infections in all units fell far below 80%. The QA/QI Council Report, September 25, 2013, for nursing's percentage of compliance for Seizure Management in Unit 2 was reported as 46% with an overall average of 84%. In averaging the three units' Seizure Management data, there was either an error in Unit 2's calculation of percentage of compliance or in the overall average percentage of compliances. If 46% compliance was correct, then, the overall percentage of compliance should have been 75.3%. This data should be corrected to provide an accurate measurement of compliance with the Seizure Management tool. The percentage of compliance with each health condition audited/monitored should be considered separately in order to provide a true measurement of compliance. There were no corrective action plans provided to review for systemic and/or local audit/monitoring tools that fell below 85% compliance, which is necessary to achieve compliance with the requirement of the Provision. In addition, the inter-rater reliability levels of agreement between the nursing's and QA Nurse's audit/monitoring tools should consistently achieve 80% agreement on each audit/monitoring tool. The Monitoring Team will continue to review progress made toward compliance with Quality Assurance Activities at the next compliance review.

Refer to Provision M.6 regarding information for Self-Audits on Medication Administration Records, Medicine Room Checklists, and Medication Administration Observations.

<u>Availability of Pertinent Records:</u>
The Monitoring Team completed a comprehensive record review for Individuals #151, #258, #413, #591, #251, #384, #215, #167, #96, #490, #263, and #86, and found:

- There was no difficulty in accessing the records at this compliance review.
- Individuals' All about Me Books were readily accessible to DSP staff and they knew the location of the books. The books contained Integrated Health Care Plans and DSP Instruction Sheets; under the ISP tab.
- The legibility of documentation written by the nursing staff showed improvement, but there should be an ongoing effort made to continue to improve.
- The documentation carried over the next page in the Integrated Progress Notes was not consistently correctly notated.
- The times of the entries were occasionally missing on the Integrated Progress Notes.
- The nursing staff occasionally failed use the military time on the entries of the Integrated Progress Notes, as required by the Nursing Services Policy.
- Occasionally documentation in the Integrated Progress Notes were written below the last line on

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		the page. Assessment and Documentation of Individuals with Acute Changes in Status: Morning Medical Debriefing Meetings: Since the last compliance review, the Nursing Department continued to demonstrate self-initiated efforts to improve compliance with integration of services across disciplines. This was demonstrated through the Monitoring Team's attendance at the Morning Medical Debriefing Meetings, on 10/8/13 and 10/9/10. The meetings followed a structured agenda that included reports on the following items: On-Call Physician, On-Call Psychiatrist, On-Call Psychologist, Individuals Hospitalized, Individuals Sent to the Emergency Room, Review of Follow up Items, ISP Meetings, and Missed On and Off Campus Appointments. The RN Case Manager Supervisor reports discussion and/or issues from the meetings to the RN Case Managers that required follow-up, particularly from the On-Call-Physician's reports pertinent to overnight emergency room visits problems or issues. The Monitoring Team was provided copies of the two meeting minutes for review. The meetings followed the structured agenda and appeared to improve the communication/integration between disciplines and the comprehensiveness of the reports. The Clinic RN served as a scribe during the meeting, therefore; the meeting minutes were readily available to the attendees and to other staff who may not have attended the meetings. During the Morning Medical Debriefing on 10/8/13, the attending physician provided an update on Individual #59 who was diagnosed about a year ago with a rare syndrome, Chromosome 1P36. The physician explained the impact this rare syndrome had on his neurological system and what to expect as the condition progressed. It was positive to find that individuals were being sent for genetic testing, as well as when diagnosed with particular genetic syndromes/aberrations that impacted their prognoses this was considered when assessing risks and planning for care. Clinical IDT Referrals: As was found at the last compliance review, the Facility continued to use the Clinical IDT Referral Form in morning sick call. Nursing administrative staff reported in interview that, after the individual was seen by the PCP, if a Change of Status was determined the referral form was completed, entered into the designated database. The QIDPs reviewed the database and set up an ISPA meeting to address individual's Change of Status. Improvement made to Treatment Rooms and Medical Equipment/Supplies: It was positive to find since the last compliance review that dedicated treatment rooms were being created in Driscoll and Childress. This will allow for individuals' privacy during examinations, provide the PCPs with adequate space to conduct examinations free from distraction, and adequate lighting and medical equipment to use for examinations. Two GE Carescape Vital Sign Monitors were purchased for the treatment rooms. While waiting for the treatment rooms to be completed, the nurses on these units had been using the Carescape Monitors to obtain vital signs and oxygen saturation levels. The RN Shift Supervisor/Durable Medical Equipment Nurse had evaluated the	

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		effectiveness of the Carescape Vital Sign Monitors. She reported that the nursing staff were impressed with the efficiency and accuracy of the monitor compared to the currently used wrist and upper arm blood pressure and pulse oximeters instruments, which were designed for home use. It is essential that the medical and nursing staff have medical grade instruments because the accuracy of the readings is critical in determining individuals' vital signs and oxygen saturation levels, particularly in the homes serving medically fragile individuals. In addition, the RN Shift Supervisor/Durable Medical Equipment Nurse was in the process of setting up a Central Supply Room to ensure that all needed medical supplies were readily available when needed. The Monitoring Team toured the treatment rooms and Central Supply Room, as well as inspected the Carescape Vital Sign Monitors. The progress made toward creating treatment rooms, a Central Supply Room, and the purchase of the Carescape Monitors showed promise in improving the quality of medical care provided. <u>Implementation of Nursing Protocol Care:</u> Since the last compliance review, all 23 Nursing Protocols had been implemented and 100% of the nursing staff trained on the protocols, as reported in Provision M.4. Throughout the records reviewed for Individuals #151, #258, #413, #591, #251, #384, #215, #167, #96, #490, #263, and #86, numerous examples were found in which the protocols were implemented and followed. In a review of the Acute Care Plans, relevant protocols were incorporated into the plans, as reported in Provision M.3. The protocols were also directed toward acute conditions that required short term assessments and documentation but did not require Acute Care Plans. Numerous examples were found where protocols were implemented and followed that did not have Acute Care Plans. For example: • Individual #263: On 7/30/13, the DSP reported that Individual #263 fell in the floor. The nurse completed a focus assessment and followed the When Contacting the PCP Protocol. The Fall or Suspected Fall Protocol was implemented and followed through to resolution. The documentation in the Integrated Progress Notes showed that Individual #263 did not sustain a serious injury. • Individual #591: On 8/20/13, the DSP reported that Individual #591 had an abrasion to the face. The nurse completed a focus assessment and followed the When Contacting the PCP Protocol. Topical Antibiotic Ointment (TAO) was prescribed for the abrasion to the face. The Antibiotic Therapy Protocol was implemented and followed through to resolution. The Integrated Progress Notes showed that the abrasion healed without complication. • Individual #86: On 7/23/13, experienced a 3.46 minute seizure. The nurse completed a focus assessment and followed the When Contacting the PCP Protocol. The Seizure Protocol was implemented and followed through to resolution. The Seizure Record was completed correctly. The Physician ordered emergency Onif and a consult with the Neurologist. An emergency dose of Onif was administered without side effect or adverse reaction. • Individual #86: On 9/29/13, the DSP reported Individual #96 possibly had a fever. The nurse completed a focus assessment and followed the When Contacting the PCP Protocol. A onetime	

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		dose of Tylenol 325 mg was ordered and administered. The Tylenol was effective in relieving the fever. The Elevated Temperature Protocol was implemented and followed through to resolution. The fever was resolved without complication. • Individual #153: On 7/22/13, Individual #153 experienced diarrhea upon return from a home visit. The nurse completed a focus assessment and followed the When Contacting the PCP Protocol. The physician ordered onetime dose of Loperamide 20 ml, which was administered. The Diarrhea Protocol was implemented and followed through to resolution. The diarrhea was resolved without complication. • Individual #251: On 8/11/13, the DSP reported that Individual #251 had an episode of vomiting and complained of a headache. The nurse completed a focus assessment and followed the When Contacting the PCP Protocol. The physician ordered Tylenol 325 mg and Phenergan 12.5 mg intramuscularly. The medications were administered without side effects or adverse reactions. The Vomiting Protocol was implemented and followed through to resolution. The headache and vomiting was resolved without complication. <u>Hospital Liaison Activities:</u> It was positive to find through interview with the Hospital Liaison Nurse, observation, and review of records for hospitalized and/or recently hospitalized individuals that the Hospital Liaison Nurse had continued to perform the positive practices identified at the last compliance review. Activities included: <u>Training Activities:</u> • In May 2013, provided in-service training to Nursing Administrative and Nurse Managers on Nursing Protocol: Hospitalizations, Transfers, and Discharges on paperwork needed for hospital transfers, following which, they then trained their respective staffs, resulting in 95% of the nursing staff being trained. <u>Other Hospital Liaison Nurse Activities:</u> • The Hospital Liaison Nurse maintained daily contact either by visits or telephone calls with hospital personnel regarding hospitalized individuals' health status and course of treatment. The information was documented on the Hospital Liaison Reports and in the Integrated Progress Notes, along with daily email updates to Incident Management Review Team (IMRT) members, physicians, and others as appropriate. The Hospital Liaison Nurse was backed-up by the Nurse Educator and by the Campus Shift Nursing Supervisors on weekends/holidays or at other times when Hospital Liaison Nurse or the Nurse Educator were not available. • Entered hospitalization data into the AVATAR system. • Attendance and participation at the Medical Morning Debriefing Meetings to update the team on individuals' hospital status. • Attendance and participation at individuals' pre and post hospitalization Interdisciplinary Support Plan Addendum (ISPA) meetings. • Served as a backup to the PNMT Nurse to complete PNMT Nurse Post-Hospitalization Assessments/Evaluations.	

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		• Maintained the Hospital and Emergency Room Visit Tracking Log that included verification of documentation for PNMT Nurse Post-Hospitalization Assessment/Evaluation, Hospital Liaison Report, and ISPA meeting date. • Coordinated the use of agency sitters for out of town hospitalizations, as needed. • Served as the Nursing Department's representative on the Human Rights Committee. • Completed the monthly Section I Audit Tool on post hospitalized individuals, which was reported to the QA/QI Committee. It was positive to find Collaborative Meetings between BSSLC and Scott and White-Brenham Hospital continued quarterly. The purpose of the collaborative team was to ensure continuity of care for BSSLC individuals while in the hospital. The BSSLC's integrated team, depending on the issues discussed, included Facility Director, Medical Director, CNE, Hospital Liaison Nurse, and Pharmacy Director. Typically the Scott White and Brenham Hospital representatives included the Director of Quality Management, Chief Medical Officer, Social Services Manager, and Chief Operation Officer/Chief Nurse Officer. The Monitoring Team validated the occurrence of such meetings through review of the Collaborative Meetings between BSSLC and Scott and White-Brenham Hospital minute summaries, March 2013 through September 2013. The summaries described substantive issues discussed and agreed upon to improve the continuity and quality of care provided to hospitalized individuals. The CNE stated that both facilities had found the collaboration to be a positive experience. The Monitoring Team reviewed the records for seven recently and/or currently hospitalized Individuals #61, #269, #305, #59, #332, #318, and #88. The purpose of the review was to evaluate the Hospital Liaison Nurse's activities and the nursing staff's compliance with the Hospital, Transfer and Discharge Nursing Policy. Of the individuals records reviewed, four were discharged and three remained in the hospital at the time of the review. Using a monitoring tool that included all the requirements related to the Nursing Protocol: Hospitalizations, Transfers and Discharges and Nursing Protocol: Emergency/Hospital Transfers, the results found 95% compliance with these requirements. Areas that fell below 95% but above 90% compliance included: Inconsistent documentation in the Hospital Liaison Reports regarding pre-discharge planning. There was lack of nursing staff documentation in the Integrated Progress Notes when individuals were transferred to the hospital for elective surgery. There was documentation via e-mail that the Shift Campus Nurses followed up on individuals hospitalized over the weekend. However, the information should have also been documented in the Integrated Progress Notes because e-mail communication is not part of the active record. The Monitoring Team's review of the Acute Care Plans developed and implemented associated with post-hospital discharges found: • Four of four (100%) discharged individuals had Acute Care Plans (ACPs) related to the discharge	

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		diagnoses developed, implemented, and DSP staff trained. It was positive to find that the baseline data and goals were relevant to the nursing problems identified. The ACPs were individualized and incorporated into relevant protocols, i.e., Antibiotic Therapy, Respiratory Distress/Aspiration, Urinary Tract Infection, and/or Pain. ACPs were integrated with other relevant disciplines, i.e., PNMT and PBSP. The frequency for monitoring items on the ACPs and by whom were included. The review of individuals Integrated Progress Notes showed that the ACPs associated with post hospital discharges were consistently carried out as described in the plans. Three individuals' ACPs were still in process with consistent documentation that the plans were being carried out as described. One individual's ACP was completed with consistent documentation in the Integration Progress Notes through to resolution. It was positive to find that there were numerous examples documented in the Hospital Liaison Reports and Integrated Progress Notes that demonstrated the Hospital Liaison Nurse's integration/collaboration with both hospital and Facility IDT disciplines. For example: • Individual #332 was admitted 9/12/13 to the hospital for debridement of right buttock pressure ulcer. The wound culture was positive for MRSA. Individual #332 was transferred on 9/16/13 to a LTAC facility for follow-up care with intravenous antibiotics. The Hospital Liaison Nurses' notes documented daily collaboration with the wound care nurse, other nurses, and Facility DSPs regarding management of wound care. On 10/7/13, the PNMT Nurse visited Individual #332 with the Hospital Liaison Nurse regarding physical and nutritional concerns related to changes in mobility, weight, and wound. • Individual #88 was admitted to the hospital on 9/24/13, and was diagnosed and treated for bacteremia. On 10/7/13, the Hospital Liaison Nurse noted two new wounds to right medial foot. She collaborated with the hospital nurse regarding the new wounds. A referral was made to PNMT. Reportedly, the wounds were discussed at the PNMT Committee Meeting on 10/8/13. The Monitoring Team did not attend the meeting and the minutes of the meeting were not yet available for review. On 10/9/13, the Monitoring Team, accompanied by the RN Shift Manager, observed Individual #61, who had recently returned home from having repair of a fractured left hip. At the time of the observation Individual #61 was setting in the wheelchair with her legs resting on the feet of the wheelchair. She was observed to have significant edema of the left leg. The edema for the left leg had been identified earlier in the day and was evaluated by the PCP and PNMT. Orders were written to apply TED hose in the morning and remove them before bedtime and sit in the recline at least three times a day for 20 minutes with feet elevated above the heart. The Acute Care Plan for Left Hip Fracture with Surgical Repair was revised on 10/9/13 to include the new orders. The Monitoring Team was provided a copy of the revised Acute Care Plan for Left Hip Fracture with Surgical Repair that showed the DSP Instruction Sheet was also revised and that the DSPs were instructed in the changes. At the time of the observation Individual #61 had 1:1 staff present. The All About Me Book was present in the room. The DSP was able to review and explain the care plans in the All About Me Book.	

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		The Monitoring Team attended a Post-Hospitalization ISPA meeting for Individual #318 on 10/10/13. All relevant IDT members attended and actively participated at the meeting. Individual #318 was admitted to the hospital on 9/27/13 with a diagnosis of left pleural effusion. During her hospital course the pleural effusion was relieved by a thoracentesis and later by a thorcoscopic decortication. Individual #318's attending physician lead the meeting. The physician did an excellent job describing and explaining her hospital course, health status at discharge, and health care needs upon discharge. He explained that she may experience chronic pain due to the decortication of the lung. The IDT reviewed Individual #318's risk ratings for Change of Status. It was determined that all relevant risk ratings were already rated as high. The team discussed the need for additional or changes in supports and service upon discharge home. There was more discussion regarding the potential to have chronic pain. It was decided that because of the potential for chronic pain, this would indicate a Change of Status risk rating as medium for pain. ACPs will be implemented for of pneumonia and skin integrity issues. An Integrated Health Care Plan will be developed and implemented to manage chronic pain. Individual #318's active record was brought to the meeting and was periodically referred to during the meeting. Based on the Monitoring Team's independent review of the Section M, Provision M.1 of the Presentation Book, interviews with the CNE, NOO, and Hospital Liaison Nurse, observations, review of individuals' records, and review of other related documents; if this was a standalone requirement for this Provision it would meet substantial compliance. <u>Infection Control Activities</u> The Monitoring Team validated the Infection Control information presented in the Facility's Self-Assessment through: Review of the Infection Control information presented in the Section M Presentation book for Provision M.1, which provided a significant amount of organized and detailed information regarding infection control activities; Infection Control Committee Meeting Minutes and other related documents requested; and interviews with the Chief Nurse Executive, Nursing Operations Officer, QA Nurse, Infection Control Nurses, and RN Shift Manager. Since the last compliance review, significant progress continued to be made in the overall structure and organization of the Infection Control Program. <u>Policies, Procedures, and Guidelines:</u> • Texas Department of State Health Services, Notifiable Conditions, January 2013 • DADS Infection Control Committee Guidelines, May 2013 • DADS Procedure: Guidelines for Prevention and Monitoring of Clostridium difficile Infections, July 2013 • BSSLC Policy A.5 Training Requirements, 6/5/13. This policy requires all BSSLC staff to complete their required annual trainings, including Infection Control, 30 days prior to becoming delinquent.	

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		• BSSLC Guide to Preventing Clostridium difficile Infections • BSSLC Infection Control Reference Manual (updates), 4/12/13 • BSSLC Isolation/Quarantine Procedures, 8/16/13, pending approval by the Policy and Procedure Committee <u>Training Activities:</u> • Infection Control Prevention and Practice Procedures were taught during New Employee Orientation. • Acute Care Plan training to all RN Case Managers, with emphasis placed on infection control measures/preventions was presented by the RN Case Manager Supervisor, 8/8/13. • Shigellosis Training was provided to all Unit 2 staff, September 2013. • Infection Control Nurse's Continuing Education Training: o Immunization Workshop, Texas Department of State Health Services, 4/23/13 o Essential in Infection Prevention, Terri Goodman and Associates, 7/7-8/13 o Prevention of NG Tube Misplacement; Nursing Practices, 09-06-005PR, Saxe Communication, 7/12/13 o Respiratory Care of Morbidly Obese Patient: Tracheostomy in the Obese Patient, 09-06-005PR, Saxe Communication, 7/12/13 <u>Infection Control Committee Meetings:</u> The Monitoring Team reviewed the quarterly Infection Control Committee Meeting Minutes for May 30, 2013 and August 29, 2013, and found: • According to Infection Control Guidelines the required core membership included: Administration Representative, Nursing Representative, Medical Director, and Infection Control Nurse. Ad hoc members include: Food Service, Maintenance, House Keeping, Laundry Services, Clinical Services, Residential Activities, and Employee. The Infection Control Nurse chaired the meeting. • Two of two (100%) scheduled Infection Control Committee Meetings occurred. • The Infection Control Committee sign-in sheets showed that all (100%) the core members attended, with the exception of the Administrative Representative. Few of the ad hoc members attended the meetings. Although they were ad hoc members, in order to have an effective interdisciplinary committee their participation is essential, since the Infection Control Program affects all aspects of the Facility's operation. The Monitoring Team's review of the minutes showed substantive discussions and dispensation of issues and follow up on issues from meeting minutes. Updated policy and guidelines were handed out and discussed to keep the membership informed of changes to the program. The training provided for the improvement of the Acute Care Plans was discussed. There were updates provided on the various audits tools used for infection control, as well as the various databases used to track, analyze, and trend infection control data, as reported later in the report.	

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		Infection Control Activities: • The Infection Control Nurse provided a list and frequencies of duties performed. The duties were well defined, comprehensive, and were in keeping with the requirements for long term care facilities and the Settlement Agreement. The duties were reviewed with the Infection Control Nurse, along with the Monitoring Team's validation of supporting documentation/data for the duties performed daily, weekly, monthly, semi-annually, annually, and situationally. Infection Control Nurse's duties were validated in the report below. • A review of the Environmental Rounds Minutes, March 1, 2013 through August 31, 2013, showed that rounds were made to all areas according to the required schedule. Local inspections that found deficiencies were corrected on the spot with follow-up documented to ensure corrections were made. The systemic problems found were related to improper disposal of food, which caused wild animal problems with them getting into the garbage and going into homes. The Home Team Leader staff and kitchen staff were instructed on proper disposal of foodstuff. The minutes indicated that the problem with wild animals issue and any other issues not followed-up to resolution/effectiveness of corrective actions would be reported at the next meeting. • Analysis of Handwashing Observation Monitoring data, April 2013 through August 2013, conducted on nursing, medical, CTD staff, QIDPs, administration staff, and DSPs on units/home and other locations where medical or active treatment occurred showed: Total of 406 incumbent staff and 176 new employees were observed for proper handwashing practices. The staff observed used hand sanitizer appropriately, wore gloves when needed, and washed hands properly. The plan for corrective action included: On the spot corrections. If serious problems were identified during the observations, DSP Supervisor, Home Team Leader, Unit Director, or respective supervisors were notified to develop a plan of corrective action. The Infection Control Nurse will follow-up on the corrective actions within 30 days to determine if the corrective actions were effective and/or if addition corrective actions are needed. • Infection Control data was entered into AVATAR by the RN Case Managers, as of July 1, 2013. The reliability of infection reporting included cross-checks after reviewing the Infection Control Reports from RN Case Managers, Individual Infection Control Forms, and Antibiotic Reports from Pharmacy. The Infection Control Nurse Notified the respective RN Case Managers of any discrepancies in the infection control data to ensure data are accurate and/or corrected. • A review of the monthly Real-Time Audits data, for reporting infections, varied from 76% compliance in May 2013 to 92% in August 2013. This showed the effectiveness of the efforts put forth to improve the reporting of all diagnoses and treated infections. September 2013 data was not yet available for review. • Analysis of Isolation Audit data conducted by the QA Director showed there was one incidence of C-diff where isolation was required between March 2013 and August 2013. The audit identified an issue regarding documentation of the isolation training to the DSP because the training roster could not be found and some supplies were not present when the audit was done. There was also an issue regarding the use of hand sanitizer use. Hand sanitizers are not effective against	

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		the C-diff spore. The Isolation Procedure was revised to include washing hands with soap and water when managing isolation due to C-diff. Any time isolation was used, the QA Director ensured isolation was maintained. • As of 8/1/13, approximately 80% of the existing data were entered. Immunization data was entered into AVATAR as new individuals were admitted. A review of the immunization data entered showed promise by making the data readily available for healthcare providers to use because it lists individuals' current immunizations status, the dates they were received, and the future dates when immunizations are due for revaccinations. • As of 9/1/13, 100% of individuals' were current with tuberculin skin testing (TST). • As of 9/5/13, employees with current TST and employees who had follow-up for converted skin test showed a combined completion rate of 97.3%. Three employees who had TST completed were either not read and/or filled out a past positive form because they were out on sick leave. • For the 2012 -2013 flu season, 93% of individuals' had the influenza vaccination; 2.5% had an allergy to the vaccine or refused the vaccine, and 4.5% did not have consents returned. For the current flu season, consents had gone out to families/guardians. • For the 2012-2013 flu season, 30% of the employees received the influenza vaccine. Some employees received the vaccine from their medical providers or at a flu clinic in the community. This flu season 2013-2014, the nursing staff will continue to offer the flu vaccine to employees. The influenza vaccine is not a mandatory requirement to work at the Facility. It is offered as a job benefit to those who would like to receive it. The Facility will have the employee sign a Declination for the Flu Vaccine Form for those who indicate they received the influenza vaccine from another provider. This information will be put in the staff immunization database for tracking. • Receiving the Hepatitis B vaccine series is not a mandatory requirement to work at the Facility. It is offered as a job benefit to those who would like to receive it, if they had not previously received the vaccine. • According to the 9/1/13, CDT Course Due/Delinquent list, several of the employees listed were re-hires and were in New Employee Orientation and will not complete the Infection Control training until the end of the month. The October 2013, list was not available for review. The Monitoring Team will review the infection control training at the next compliance review. • The Infection Control Nurse, at the advice of the Pharmacy and Therapeutics Committee, annually updates the Antibiogram (oral and injectable antibiotics) specific to BSSLC, which was developed based on cultures and sensitivities every six months. The Infection Control Nurse presented the Antibiogram results at the Pharmacy and Therapeutic Committee meeting for review and discussion. • A review of the Infection by Type tracked data for the third and fourth quarters showed:	

Infection by Type	3/1/13/through 5/28/13	5/29/13 through 8/31/13
Lower Respiratory Infections	4	3
Urinary Tract Infections	13	27

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Multi-Drug Resistant Organisms (MDROs)	2	1
Soft Tissue Infections	27	6
Internal/External Otitis Infections	2	2
Ophthalmic (Conjunctivitis) Infections	14	7

- Over the past six months the Facility reported: Twelve cases of Shigella, five cases of MRSA, and one case of Herpes Zoster. The infection data showed a decrease in the number of ophthalmic infections and an increase in the number of urinary tract infections. The urinary tract infections reported were based on cultures and sensitivities studies. The Infection Control Nurse should continue to explore the underlying causes and contributing factors leading to urinary tract infections in collaboration with the primary care providers (PCPs), Infection Control Committee, PNMT Committee, and IDT members. The Monitoring Team will follow-up on the ongoing analysis and trending of urinary tract infections at the next compliance review.

The Monitoring Team toured the Central Kitchen on 10/8/13, accompanied by the RN Shift Manager. The Food Service Manager provided a tour throughout all areas of the kitchen, showed and explained how various food products were stored and used. The kitchen was clean and well organized. The quality of the food products observed appeared of good quality and in date.

Refer to Provision M.3 for report on recent and/or active Acute Care Plans for Reportable Communicable Diseases and Urinary Tract Infections.

Based on this compliance review, the Infection Control Program was well organized and managed and met the generally accepted standards of infection control for long term care facilities. If the Infection Control Activities for this Provision was a standalone requirement it would be considered in substantial compliance.

<u>Skin Integrity Activities:</u>
The Monitoring Team validated the Skin Integrity information presented in the Facility's Self-Assessment through: Review of information presented in the Section M, Provision M.1 of the Presentation book. Reviewed Skin Integrity Committee Meeting Minutes and other related documents requested. Conducted interviews with the Chief Nurse Executive, Nursing Operations Officer, and Nurse Educator/Skin Integrity Nurse. Reviewed a sample of individuals' records that had active pressure ulcers. Relevant Self-Assessment data were updated during the onsite compliance visit. Findings included:

<u>Training Activities:</u>
- Skin Management and Wound Prevention with competency-based testing were provided to all new nurses during orientation and at the annual competency refresher training.
- Nursing Protocols: Skin Management and Wound Prevention and Hospitalization and Discharges were provided to Nurse Managers who provided the training to their nursing staff for a total of

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		95% of the nursing staff. • Seventeen DSP staff at Bowie and Driscoll were provided training on Pressure Ulcer Prevention with emphasis placed on the importance of notifying the nurses of individuals with skin integrity issues. <u>Other Skin Integrity Nurse Activities:</u> • The Nurse Educator took over as the Skin Care Committee Chairperson August 1, 2013. Since that time she had begun to make significant improvements in the management and reporting of skin integrity issues. Future plans for improvement included: o Continue to train all new nursing staff on use of E-Z Graph and Push Tools. o Monitor Nursing Care Plans that are initiated to ensure appropriateness. o Continue to monitor skin integrity trends. o Continue to ensure the Skin Integrity Database is updated correctly. o Attend wound care seminars and certifications courses. o Utilize the database to track pressure ulcers using the monthly pressure ulcer data for the campus from the Plan of Improvement (POI) Reports. The Monitoring Team reviewed the quarterly Skin Care Committee Meeting Minutes for April 24, 2013 and July 24, 2013 and found: • The Skin Care Committee was comprised of interdisciplinary team members. Core membership included: Skin Integrity Nurse, Chairperson, CNE, NOO, Medical Director, Habilitation Representative, QA Nurse, Infection Control Nurse, Psychology Representative, QIDP Representative, Direct Support Professional Representative, and Dietitian. • Two of two (100%) scheduled Skin Care Committee Meetings occurred. • The Skin Care Committee sign-in sheets showed respectively 91% and 83% of the core membership attended the meetings. • The Monitoring Team reviewed the Skin Care Committee Minutes and found: The committee routinely reviewed data from the Plan of Improvement (POI) reports, chart audits completed by the Infection Control Nurse, and other issues related to campus-wide skin integrity. It was positive to find since the last compliance review, that the Dietitian had been added to the core membership. In the April 2013, meeting there was a discussion regarding replacing and discarding old mattresses. The outcome of the mattress discussion included an agreement to replace old mattresses with the GEO 350 standard mattresses from the warehouse. Skin Integrity Nurse provided a position paper on surface Selection for Prevention of Pressure Ulcers, from research data provided at the National Pressure Ulcer Advisory Panel (NPAUP) in February 2013. The research found for individuals who lack enervation of the muscle or do not move voluntarily, the foam with gel overlay products for pressure relief are better alternatives to Air Cell products. Considering the high incidences pressure ulcers reported, it was positive to find the old mattresses were being replaced with pressure relief surface mattresses. Most pressure ulcers are the result of unrelieved pressure. Pressure relief surface mattresses, in addition	

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		proper repositions, and sound nutrition, serve as essential measures to reduce, if not prevent, the development of pressure ulcers. There was no discussion in the July 2013 minutes regarding the status of replacing old mattresses with the GEO 350 pressure relief mattresses. In the July 2013 Skin Care Committee Minutes, the committee reviewed the Pressure Ulcer Database Report for current/active wounds, as of 7/24/13, and discussed again the possibility that all wounds were not being tracked. As a result of this discussion the committee agreed, "that even though our tracking may not be perfect, we are doing a far better job now that 2 years ago." The committee agreed to continue monitoring the wound database and POI reports at each quarterly meeting. It was deeply concerning to the Monitoring Team that the committee agreed to continue to monitor the wound database and POI reports, while acknowledging the possibility that all pressures ulcers were not being tracked. The committee should have been proactive and explored the reason all pressure ulcers were not reported and have taken corrective action to ensure all were reported. It is essential to have accurate pressure ulcer data to track, analyze, and trend for the purpose of making clinical decisions to prevent the development of pressure ulcers. The Facility should have zero tolerance for the development of pressure ulcers. The Decubitus Report for April 2013 through August 2013 is reported in the chart below:	

Pressure Ulcer/Decubitus Data	April 2013	May 2013	June 2013	July 2013	August 2013
Number of Individuals with Pressure Ulcers (Unduplicated)	7	4	6	6	7
Number of Pressure Ulcers - acquired in the facility	6	4	7	7	14
Number of Pressure Ulcers - acquired outside the facility	2	1	0	0	0
Stage I —A persistent area of skin redness (without a break in skin) that does not disappear when pressure is relieved.	0	0	0	0	0
Stage II —A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater.	6	3	4	5	14
Stage III —Full thickness skin lost, exposing the subcutaneous tissue - presents as deep crater with or without undermining adjacent tissues.	1	1	1	0	0
Stage IV-Full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	1	1	1	1	0

#	Provision	Assessment of Status	Compliance

Unstageable-Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed	0	1	1	1	0
Suspected Deep Tissue Injury	1	0	0	0	0

*The September 2013 was continuing to be analyzed and trended was not yet available to review in detail.

Since the last compliance review, as the chart demonstrates, there had been a significant increase of approximately 50% in the number of unduplicated pressure ulcers, particular Stage II pressure ulcers, as well as the number of pressure ulcers occurring at the Facility. The Skin Integrity Nurse stated that the accuracy of the data was questionable and that she was analyzing the reporting of data to ensure accuracy. From a review of individuals' records it appeared that once the pressure ulcers were discovered, appropriate nursing care plan for pressure ulcer management, medical care, and PNMT assessments for pressures and pressure relieve measures were put in place. The old mattresses had been replaced with the GEO 50 Standard pressure relieving mattresses. It was of concern to the Monitoring Team that more was not done to analyze the underlying cause and/or contributing factors that lead to the pressure ulcers. The Facility should have zero tolerance for the development of pressure ulcers. In the next six months the Skin Integrity Nurse in collaboration with the Skin Integrity and PNMT Committees should explore the underlying and/or contributing factor that cause pressures ulcer. The Facility must ensure that DSPs are trained to recognize and report immediately the first indication of pressure on any body part such that early intervention is provided to relieve the pressure and prevent further skin breakdown

The Monitoring Team reviewed three the records on individuals' with recently or currently active pressure ulcers, Individuals #332, #88, and #38. The Acute Care Plans for pressure ulcers showed significant improvement in the individualization, comprehensiveness, and quality. Findings for the review of Acute Care Plans included:

- One of three (33%) plans were initiated promptly upon identification of the problem.
- Two of three (67%) plans when initiated were documented in the Integrated Progress Notes.
- Three of three (100%) plans had baseline data sufficient to identify the skin integrity issue that led up to the necessity for care plans.
- Three of three (100%) plans had goals sufficient to identify the desired outcomes of for which the care plans were design to resolve.
- Three of three (100%) plans were individualized care plans sufficient to meet the individuals' identified problem.
- Three of three (100%) plans incorporated relevant protocols and physician orders for treatment.
- Three of three (100%) plans included integration of care with other relevant disciplines.
- Three of three (100%) plans included how frequently interventions were to be completed, by whom, and where documented.
- Three of three (100%) plans included relevant preventative measures.
- Two of three (67%) plans were review and/or revised when indicated by change in condition or

#	Provision	Assessment of Status	Compliance
		plans were not effective. • Three of three (100%) plans included DSP Instruction Sheets. • Three of three (100%) plans' DSP Instruction Sheets were individualized sufficient to meet individuals' health care needs that were applicable to individuals' specific skin integrity issues. • Three of three (100%) plans had documentation that DSP staff were trained on the plans. • Zero of three (0%) Integrated Progress Notes showed that the plans were consistently carried out as described in the plans and followed through to resolution, when applicable. The overall Acute Care Plans achieve an 83% compliance score. Although improvement was found in the Acute Care Plans regarding individualization, comprehensiveness, and quality; there were delays in initiating Acute Care Plans and inconsistent documentation in the Integrated Progress Notes that the plans were carried out as described. The following issues were identified: • Individual #88: Records were review from 5/20/13 through 10/7/13 regarding the diagnoses of pressure ulcers over lying the left ischial tuberosity, sacrum and right foot. The open area to the left hip was observed on 5/15/13, and reported to the physician who saw the individual in sick call and diagnosed the pressure ulcer on the left tuberosity and order treatment. However, the Acute Care Plan was not initiated until 5/23/13, when the RN Case Manager completed the Quarterly Nursing Physical Assessment using the PUSH Tool and E-Z Graph and the ulcer was determined as unstageable. It was of concern to the Monitoring Team that there was an eight-day delay in initiating the Acute Care Plan for Impaired Skin Integrity Related to Pressure Ulcer Left Buttock. The plan should have been initiated promptly when the pressure ulcer was diagnosed. It was positive to find that the care plan was reviewed and revised on 8/2/13, when Individual #88 reopened areas on the sacrum and developed two uncapped blisters on the lateral right foot. A review of the Integrated Progress Notes found there were gaps in nursing documentation regarding assessment and management of the wounds according to the frequency stated in the Acute Care Plan. • Individual #332: On 6/10/13, the physician was call to check a sore on the left lateral foot. The individual's left foot was assessed as a Stage II pressure ulcer. There was no nursing documentation regarding assessment of the pressure ulcer in the Integrated Progress Notes until 6/18/13, when an RN completed an E-Z Graph assessment, which identified the pressure ulcer at Stage II. There was no further documentation regarding the pressure ulcer until 6/24/13, when the Skin Integrity Nurse was requested to assess the wound. The Acute Care Plan for Pressure Ulcer to Left Foot was not initiated until 6/27/13. The wound was resolved on the plan and documented in the Integrated Progress Notes on 8/13/13. However, other nursing documentation in the integrated Progress Notes regarding assessments and management of wound care were inconsistent. On 8/6/13, the RN using the PUSH Tool and E-Z Graph assessed two Stage II pressure ulcers on the right buttock. There was no further documentation regarding the assessment and management of the pressure ulcers documented in the Integrated Progress Notes until 8/20/13	

#	Provision	Assessment of Status	Compliance
		and 8/26/13, when Push Tool and E-Z Graph assessments were completed and showed both pressures ulcers on the right buttock remained at Stage II. On 8/23/13, there was documentation that an Acute Care Plan was initiated for Pressure Ulcer Right Buttock. It was of concern to the Monitoring Team that there was a 17-day delay in initiating the Acute Care Plan for Impaired Skin Integrity Related to Pressure Ulcer Right Buttock. The plan should have been initiated promptly when the pressure ulcer was diagnosed to ensure interventions were put in place to address and resolve the pressure ulcer. There was no further nursing documentation in the Integrated Progress Notes regarding the assessment and management of the pressure ulcers, 8/23/13 through 8/29/13. Individual #332 was admitted to the hospital for elevated temperature secondary to MRSA, 8/29/13 through 9/6/13. Upon return home the nurse's post-hospital assessment documented there was no drainage from the pressure ulcer on the right buttock.. There was no further description of the size, shape, depth or appearance of the pressure ulcer. There was no review and/or revision to the Acute Care Plan post-hospitalization. There were no PUSH Tool and E-Z Graph assessments completed after hospitalization until the Skin Integrity Nurse was requested on 9/11/13, to complete the assessments. She stated that the pressure ulcer to the right buttock appeared to be a Stage III or IV. It could not be determined if the wound progressed from a Stage II during hospitalization or since his return. The physician was notified of the findings. Individual #332 was seen by the wound care physician on 9/12/13 and was sent to the hospital the same day for debridement of the pressure ulcer on 9/13/13. Subsequently, Individual #332 was admitted to a Long Term Acute Care (LTAC) facility for follow up care. It was of concern that a more definitive assessment of the pressure ulcer was not completed using the Push Tool and E-Z Graph upon return from the hospital on 9/6/13. Perhaps, if such an assessment had been completed the advancement of the pressure ulcer to Stage III or IV could have been identified earlier and necessary treatment rendered. Based on this compliance review, the Facility should continue positive practices identified in the report and make improvements by working collaboratively with the Skin Integrity and PNMT Committees and IDTs to reduce/prevent the incidences pressure ulcers. This requirement for this Provision did not meet substantial compliance. The Facility for the next six months should focus on preventing pressure ulcers. <u>Emergency Response Activities:</u> The Monitoring Team validated the Emergency Response information presented in the Facility's Self-Assessment through: Review of the Emergency Response information presented in Provision M.1 of the Section M Presentation book, review of Emergency Response Committee Meeting Minutes and other related documents and observations. Findings included: • As was found in the last compliance review, the Facility had maintained the positive practices previously identified and reported by continued adherence to the Emergency Response, Policy Number: 044.2, along with making additional improvements to their emergency response system that went beyond the requirements of the policy. There was no change to the Emergency Response Policy.	

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A review of the quarterly CPR/Emergency Response Committee Meeting Minutes showed two of two (100%) scheduled meetings occurred, with 100% of the membership attending the meetings. The Committee was chaired by the CNE. The Committee's integrated core membership was comprised of Medical Director or designee, QA Nurse, QA Director, Risk Manager, Unit Nurse Managers, CTD Director, and Residential Services Representative. A view of the minutes and attendance at the meeting further revealed that all relevant aspects of the Facility's emergency response system were addressed, areas needing continued improvement were identified, and plans of improvement/corrections were addressed. The minutes also showed the committee continued to be dedicated to continuously improving their emergency response system. For example, in April 2013, the CNE developed and implemented a CPR Mock Drill Summary that evaluated the outcome of the drills, which included the date, time, home, instructor, corrective action needed, and if needed to date training was completed and by whom. There had been no actual code events since the last compliance review.
The Facility continued to conduct Mock Medical Emergency Drills according to the Emergency Response Policy. Mock Medical Emergency Drill data were reported to the QA Department on a quarterly basis for analysis and trending. The Monitoring Team reviewed the result of the drills from May 2013 through July 2013, and reported to the QA/QI Council on September 25, 2013. This data are represented in the chart below. The drill data for August and September 2013 were not yet available for review.

<table>
<tr><th>Mock Medical Emergency Drills</th><th>May 2013</th><th>June 2013</th><th>July 2013</th><th>Overall</th></tr>
<tr><td>Scheduled</td><td>9</td><td>9</td><td>9</td><td>27</td></tr>
<tr><td>Completed</td><td>9</td><td>9</td><td>9</td><td>27</td></tr>
<tr><td>Passed</td><td>9</td><td>9</td><td>9</td><td>27</td></tr>
<tr><td>Percent Passed</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Percent Completed</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
There was no corrective action plan needed as a result of the QA/QI Council's review of the Mock Medical Emergency Drill data.

The CNE continued to report all drills to Incident Management Team for review. If plans of corrections were needed, the information was sent to the respective Unit Directors for follow up and training.
The CNE maintained a CPR Mock Drill Database that recorded all drills performed and the outcome results. The Monitoring Team's review of the CPR Mock Drill Database, April through July 2013, summarized and described the results of each drill performed. All drills were passed during this reporting period. Occasionally, it was reported that individual staff required onsite retraining by drill instructor. Then, the drill was repeated and the drill was passed. There were no staff reported that needed retraining by CTD.
The number of drill instructors conducting the Mock Medical Emergency Drill was reduced to a core group of six, which included the Compliance nurse, Night Nursing Supervisors and CTD staff.

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Competency training was provided to this group on the use of emergency equipment and what staff responsibilities were during the drills. Due to staff changes, the Emergency Response Committee decided to add additional drill instructors. Once these staff were selected, they received competency based training on conducting the drills.
• The Facility continued to maintain a list of the locations and extension phone numbers for emergency equipment and Automated External Defibrillators (AEDs) throughout the campus. Signs continued to be visually posted on the walls throughout the campus directing the observer to the location of the emergency equipment and AEDs.
• The nursing staff continued to check their respective units and other assigned areas of campus emergency equipment and AEDs daily and sign the Emergency Equipment and AED Checklists. The Unit Nurse Managers monitored the Emergency Equipment and AED Checklist at least monthly for compliance. The Risk Manager continued to conduct monthly Emergency Equipment and AED Walkthroughs and sign the Checklist to confirm that all emergency equipment and AEDs were present and in good working order. The Nursing Department monthly tracked and analyzed the Emergency Equipment and AED Checklists to ensure that they were checked according to policy and to ensure corrective action was taken when deficiencies were identified. The chart below represent the monthly percentage of compliance with checking emergency equipment and ADEs throughout campus:
Emergency Medical Checklist Summary, April through July 2013:
<table>
<tr><td>April 2013</td><td>May 2013</td><td>June 2013</td><td>July 2013</td></tr>
<tr><td>99.6%</td><td>98.8%</td><td>100%</td><td>95.6%</td></tr>
</table>
Data was not yet available to review for August and September 2013.
• The Monitoring Team's review of the CTD Course Due/Delinquent List, printed 10/14/13, showed there was no employees' due/delinquent in Basic Life Support (BLS) for Healthcare Providers training. There were several newly hired employees on the CTD Course Due/Delinquent List that not yet completed the Basic CPR Course. The CTD Course Due/Delinquent List will be reviewed at the next compliance review to ensure that all employees are current in BLS for Healthcare Providers and Basic CPR.

During the compliance review, the Monitoring Team accompanied by the CNE, RN, Shift Supervisor and respective Nurse Managers, conducted inspections/observations of emergency equipment in Bowie, Childress, Fannin, and Program Services. All of the required emergency equipment was present and in good working order, daily Emergency Equipment and AED Checklists were checked daily, and the Walkthrough Emergency Checklists by the Risk Manager were checked monthly per policy. It was positive to find that the staff nurse in Childress observed at the last compliance review and who failed to demonstrate competency in operating the emergency equipment had been retrained. This nurse was observed and was able to competently operate the emergency equipment.

On 10/10/13, the Monitoring Team observed an impromptu Mock Medical Emergency Drill in Driscoll A conducted by the CTD Drill Instructor, accompanied by the CNE, RN Shift Supervisor, and
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#	Provision	Assessment of Status	Compliance
		Unit Director. The scenario used was "man down" in bed with side rails up. It was positive to find that when the drill was called the nurse immediately responded and removed the "man down" onto the floor and began CPR. The other staff responded accordingly and the drill ultimately passed. The Facility continued to demonstrate substantial compliance with the Emergency Response, Policy Number: 044.2, as well as making additional improvements beyond the requirements of the policy. An additional observation made during a tour of the Main Kitchen was that on their Bulletin Board, clearly visible was a sign that gave all of the contact information for responding to a medical emergency. <u>Conclusion</u> The Facility's Provision M.1 Self-Assessment stated they were in substantial compliance with this Provision. The Monitoring Team did not concur based on the high incidences of decubitus/pressure ulcers. The reduction/prevention of decubitus/pressure ulcers is not solely up to the Skin Integrity Nurse to resolve. It is the responsibility of the Facility to develop a zero tolerance for decubitus/pressures ulcer and for all relevant disciplines to work collaboratively to reduce/prevent their occurrences. All of the other requirements for this Provision were found in substantial compliance. The positive practices found must be maintained, with a need to continue to demonstrate effective steps over time to make improvements when needed.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.2's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, and RN Case Manager Supervisor; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.2 and the Monitoring Team concurs with their findings. <u>New/Revised Policies, Procedures, and Protocols:</u> • DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, April 2013 • DADS Policy 010.3, Nursing Services, 6/17/13 <u>Summary of RN Case Managers Training Provided by RN Case Manager Supervisor:</u> • On 4/16/13, 19 of 19 (100%) were trained on the new Guidelines: Comprehensive Nursing Review/Nursing Quarterly/Physical Assessment. • On 5/3/13, 19 of 19 (100%) were trained on safety related to independent ambulatory individuals with free movement over campus.	Substantial Compliance

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On 5/9/13, 17 of 19 (89%) were trained on the revisions to the Integrated Risk Rating Form; new quarterly forms for physical and chart audits; new Annual Comprehensive Nursing Review and Physical Assessments; AVATAR for entering MOSES and DISCUS; WORx for medications; and review of abuse/neglect/and exploitation requirement. Later, two additional RN Case Managers were trained.
On 5/28/13, 18 of 19 (94%) were trained on the new audit Tools for Urinary Tract Infection and Temperature Elevation; discharge summaries and teaching group home nurses; Health Center tracking Tools required by hospital regarding family contact and agreement for sedation/contrast dyes with an accompanying Integrated Progress Note for family/guardian response. Later one additional RN Case Manager received the training.
On 6/26/13, 19 of 19 (100%) were trained on: Community Placement Process, including Nursing Discharge Summaries, and training group home agency staff on information contained on the Nursing Discharge Summaries; monitoring monthly weights with dietary changes; new nursing procedure for G-tube insertion in stomas less than three months old; documentation related to death review recommendations; Nursing Services Policy to correspond to Psychiatry Policy related to MOSES and DISCUS requirements; and responsibility for entering infections into AVATAR beginning in July 2013.
On 8/8/13, 19 of 19 (100%) were trained/reviewed on Acute Care Plan requirements.

<u>Facility's Self-Assessment Quality Assurance Data for Comprehensive Nursing Assessments:</u>
According to the Annual Nursing Assessment data for May 2013 through July 2013, reported in the QA/QI Council Report, September 25, 2013, the percentage of compliance found through auditing/monitoring conducted by nursing auditors and the inter-rater reliability level of agreement found by the QA Nurse was:
Nursing Department's Auditing/Monitoring Data
<table>
<tr><td>Nursing Audit/Monitoring Tools</td><td>Unit 1</td><td>Unit 2</td><td>Unit 3</td><td>Overall Average</td></tr>
<tr><td>Annual Nursing Assessment</td><td>86%</td><td>91%</td><td>97%</td><td>90%</td></tr>
</table>
QA Nurse's Auditing/Monitoring Data
<table>
<tr><td>Nursing Audit/Monitoring Tools</td><td>May 2013</td><td>June 2013</td><td>July 2013</td></tr>
<tr><td>Annual Nursing Assessment</td><td>94%</td><td>89%</td><td>N/A*</td></tr>
</table>
*Data not yet available for review.

<u>The Monitoring Team's Review of Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment:</u>
Since the last compliance review the Nursing Department had fully implemented the recently revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment forms (it should be noted a new standard assessment format had been implemented 10/1/13, but assessments in that format were not available). Although the revised forms contained essentially the same assessment items, the Quarterly Nursing Record Review forms did not include a specific section for some of the information addressed/assessed on the former Comprehensive Nursing Assessment
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#	Provision	Assessment of Status	Compliance
		Form used for completing the quarterly nursing assessments. According to the guidelines these assessment items were to be summarized on XI: Nursing Summary on the Quarterly Nursing Record Review form. Otherwise this information would not be addressed and/or assessed until the next annual nursing assessment. XI Nursing Summary instructions included documentation of the following information: o A summary of analysis of findings and additional information related to plan of action and other notes (e.g., referral, pending appointments) relevant to the individuals served. A summary of the progress made during the quarter or year. o A review of Self-Administration of Medication (SAM) Program status, current health risks, pertinent surgeries, nursing problems/diagnoses identified and reason for diagnoses and recommendations. o The inclusion of individuals' preferences, strengths, goals, and progress made on Integrated Health Care Plans, and other plans as appropriate. o The inclusion of recommendations regarding community integration. o The inclusion of the RN Case Manager's signature/date and check box marked indicating it was provided to the QIDP and other IDT members. However, the state standardized form did not include a check box for indicating notification of the QIDP and IDT members. The check box should be added to ensure the QIDP and IDT members were notified. o Post an electronic copy of the final document in the designated Facility share folder for access by all IDT members. The Monitoring Team reviewed a sample of 12 recently completed Admission, Annual Comprehensive Nursing Assessments and/or Quarterly Nursing Record Review/Quarterly Physical Assessments, which were selected from the Facility's At Risk List for individuals identified at high/medium risk health conditions and from each unit for Individuals #151, #258, #413, #591, #251, #384, #215, #167, #96, #490, #263, and #86. The 12 Admission/Annual Comprehensive Nursing Assessments and/or Quarterly Nursing Record Review/Quarterly Physical Assessments were reviewed using a monitoring tool comparable to the tool used by the Facility, which included the requirements in the revised Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment found: • Three of three (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. • One of two (50%) Annual Comprehensive Nursing Assessments were completed 10 working days prior to the date of the ISP meetings. However, the other nursing assessment was completed but it was three days late. • Seven of seven (100%) Quarterly Nursing Record Reviews/Quarterly Physical Assessments were completed by the last day of the month in which the quarterly nursing assessment was due.	

#	Provision	Assessment of Status	Compliance
		According to the nursing assessment monitoring tool used by the Monitoring Team, an overall compliance score of 93% was achieved. This showed continuous improvement to the completeness, accuracy, and quality of the Admission, Annual and/or Quarterly Comprehensive Nursing Assessments from previous compliance reviews, which was found to have an overall compliance score of 90%. This was relatively consistent with the nursing assessment quality assurance data reported to the QA/QI Council Report in September 2013. The items that fell below 93% included: • Two of eight (75%) new Admission and/or Annual Comprehensive Nursing Assessments lacked consistency between the current active medical problems listed on the admission and annual nursing assessments' and the physicians' current active medical problem lists. • Although the overall nursing summaries in XI: Nursing Summary section for both the annual and quarterly nursing assessment regarding the clinical data for each identified nursing problems/diagnoses were summarized accurately and succinctly, the summaries did not consistently qualify for every problem/diagnosis the clinical data by indicating whether or not progress was made toward the stated goals and/or the effectiveness of the of health care plans. In most cases, the summary of progress was made for nearly all, but a qualifying statement was not made for one. <u>Nursing Discharge Summaries and accompanying Discharge Packets:</u> During the last compliance review, the Most Integrated Setting Practices Policy was reviewed with the State Office Nursing Coordinator. It was discovered there were no instructions identifying the RN Case Managers' role and responsibilities for completing the Nursing Discharge Summary form. She agreed that more specific instructions should be developed. Subsequently, the State Office Nursing Coordinator provided additional instruction on 5/24/2013, via email. As reported above 19 of 19 (100%) RN Case Managers were trained on Community Placement and Nursing Discharge Summaries. The instruction included: • State Supportive Living Center (SSLC) nurses are responsible for reviewing/training the group home nurses on the following items,(as applicable): o Preferences o Special Instructions o Medications listed o Immunization Records o MOSES/DISCUS o IRRF o Integrated Health Care Plan (IHCP) and/or HMPs or ACPs, as applicable o DSP Instruction Sheets Documentation validated that the Facility nurses reviewed/trained the group home nurses on the information listed above.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team reviewed five Nursing Discharge Summaries and accompanying Discharge Packets for Individuals #510, #244, #260 #479, and, #316, who were recently discharged into community living. Since the last compliance review, the review found significant improvement had been made in completing the Nursing Discharge Summaries and in the supporting documentation contained in the Discharge Packets: Findings included: • Five of five (100%) Nursing Discharge Summaries were within 45 days prior to individuals' discharge into community living. • Five of five (100%) Nursing Discharge Summaries included individuals' assessments, clinical services' needs, and health status in relation to each significant identified health clinical indicator, such that the receiving agency could understand their present health status in order to respond to their health care needs. • Five of five (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' preferences. • Five of five (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Special Instructions. • Five of five (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' medications. • Four of five (80%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Immunization Records • Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' MOSES/DISCUS, as applicable. • Five of five (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IRRF. • Five of five (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IHCP and/or other related health care plans, as needed. • Five of five (100%) Discharge Packets contained documentation of review/training provided to the group home nurses on individuals' DSP Instruction Sheets. The Facility's Self-Assessment stated they were in compliance with this Provision. This Provision continued to meet substantial compliance. The positive practices found must be maintained, with a need to continue to demonstrate effective steps over time to make improvements when needed.	
M3	Commencing within six	<u>Monitoring Team's Findings:</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.3's Presentation Book; review of documents requested; meetings/interviews with CNE, NOO, and RN Case Manager Supervisor; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.3; the Monitoring Team did not concur with this assessment but would like to recognize the significant progress made to date. Refer to Provision M.2 regarding new/revised policies, procedures, and/or guidelines, as well as training provided the RN Case Managers. <u>Monitoring Team Review of Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs):</u> The Monitoring Team reviewed three new admission IHCPs for Individuals #384, #263, and 251 and five recently completed annual IRRFs IHCPs submitted in the document request for Individuals, #153, #258, #413, #591 and #251, with focus on areas for which nursing were responsible, along with supporting documentation that validated the implementation of the plans. Of the eight individuals' IHCPs reviewed: • Eight of eight (100%) were found to have an IHCP addressing their high-risk health/mental health indicators. • Eight of eight (100 %) IHCPs included integrated baselines risk rating areas for which nursing were responsible for were stated succinctly and precisely relating to identified health conditions' clinical data that lead to the necessity for IHCPs. • Seven of eight (88%) of the integrated goals listed in the IHCPs were clinically appropriate, as related to nursing interventions. • Seven of eight (88 %) the IHCP goals included expected outcomes that were stated in objective, measureable, and observable terms related to plans' interventions. • Eight of eight (100%) of the IHCPs for which nursing was responsible were found to be clinically sufficient. However, the action steps included related to nursing responsibilities were brief and general and lacked sufficient specificity. The Monitoring Team was able, in reviewing other documentation, to find examples that supported an inference that more specific actions were carried out, but these were not clear in the nursing interventions as stated in the IHCPs. The action steps for nursing interventions need to contain more specificity as what was monitored and documented. • Eight of eight (100%) IHCPs, all interventions, including DSP staff training, were in accordance with generally accepted nursing practices related specifically to individuals' health conditions. • Eight of eight (100%) of the IHCPs contained adequate proactive/preventative interventions to reduce and/or eliminate risk indicators/health conditions. • Eight of (100%) of the IHCPs were sufficiently individualized.	

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		• Eight of (100%) of the nursing interventions contained in the IHCPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. • Eight of eight (100%) nursing interventions contained in the IHCPs were implemented as written, unless the IPNs/monthly reports provided an explanation for any delays and a plan for completing the action steps. • Eight of eight (100%) nursing interventions listed in the IHCPs were either ongoing and/or were implemented within 14 working days of approval, unless there was an explanation for the delay, i.e., scheduling appointment or procuring needed equipment/supplies. Since the last compliance review, there was significant improvement found in the quality and comprehensiveness of the IRRFs' high and or medium clinical data that lead to the necessity for IHCPs. The clinical data in the IRRF listed Health Management Plans that were in place. They were to be discontinued and replaced by IHCPs when finalized by the IDTs. The response to the IHCPs related to nursing intervention and their effectiveness are to be reported in the Nursing Quarterly Reports. The Facility's Self-Assessment stated, "The Annual Nursing Care Plan Monitoring Tool had showed a quarterly 72% in for the quarter in July and a quarterly 79% in October. Based on these results, on 8/8/2013, the Case Managers were retrained on the process with 100% completing the training. Improvement has been since the training. The Case Manager Supervisor will follow up with corrective action as needed. Comparison of Nursing/QA Inter-Rater Reliability Tracking and Trending for Annual Nursing Care Plans shows 70% in July. This process has changed due to the implementation of the IHCP. It was noted that Section M Monitoring Tool regarding care plans was not effective in measuring the new IHCP process." The process for evaluating compliance with the IHCP appears to be evolving and, with more time and experience may lead toward compliance. <u>Monitoring Team Review of Acute Nursing Care Plans (ACPs):</u> The Monitoring Team's review of the Facility's Self-Assessment and Provision M.3's Presentation Book showed that the RN Case Manager Supervisor had continued to make a concerted effort to perfect the ACPs. The ACPs were exemplary. This was evidenced in reviewing the recent and/or currently active ACPs for Reportable Communicable Diseases, Urinary Tract Infections and Pressure Ulcers. The Monitoring Team reviewed records for 12 cases of reportable communicable diseases for Shigella for Individuals #264, #582, #247, #132, #51, #523, #193, #191, #33, #412, #226, and #50. The 12 individuals' resided in Childress A, B, C, and D. Because of the aggressive preventative measures put in place, the spread of Shigella was limited to Childress. • The Shigella Sign-in Training Rosters showed that all direct care nurses and DSP in Childress	

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		were trained. • The review of the active records showed: o Twelve of 12 (100%) cases of Shigella were diagnosed by positive stool cultures. o Twelve of 12 (100%) individuals diagnosed with Shigella had exemplary Acute Care Plans developed and implemented to manage care. They showed significant improvement since the last compliance review. Findings from review of the Acute Care Plans and accompanying Integrated Progress Notes showed: ▪ Twelve of 12 (100%) Integrated Progress Notes showed nurses followed the Nursing Protocol: "When contacting the PCP, document that you provided the following..." was followed when individuals' experienced an acute change of status related to Shigella. ▪ Twelve of 12 (100%) Acute Care Plans were initiated promptly upon diagnoses of Shigella. ▪ Twelve of 12 (100%) Acute Care Plans had baseline data sufficient to identify the signs/symptoms of Shigella that led up to the necessity for care plans. ▪ Twelve of 12 (100%) Acute Care Plans had goals sufficient to identify the desired outcomes of for which the care plans were design to resolve the Shigella. ▪ Twelve of 12 (100%) Acute Care Plans were individualized sufficient to meet the individuals' health care needs for managing Shigella. ▪ Twelve of 12 (100%) Acute Care Plans incorporated relevant protocols and physician orders for treatment, including Nursing Protocols for: Antibiotic Therapy, Diarrhea, Elevated Temperature, pain, Universal/Contact Isolation Precautions. ▪ Twelve of 12 (100%) Acute Care Plans included integration of care with other relevant disciplines. ▪ Twelve of 12 (100%) Acute Care Plans included how frequently interventions were to be completed, by whom, and where documented. ▪ Twelve of 12 (100%) Acute Care Plans included DSP Instruction Sheets. ▪ Twelve of 12 (100%) Acute Care Plans' DSP Instructions Sheets were individualized sufficient to meet individuals' health care needs and to prevent the spread of Shigella. ▪ Twelve of 12 (100%) Acute Care Plans' DSP Instructions sheets contained documentation that DSPs were trained. ▪ Nine of 12 (75%) Integrated Progress Notes documented that Acute Care Plans for Shigella were initiated. ▪ Twelve of 12 (100%) Integrated Progress Notes documented that Nursing Protocols for: Antibiotic Therapy, Diarrhea, Elevated Temperature, pain, and Universal/Contact Isolation precautions were consistently followed. ▪ Twelve of 12 (100%) Integrated Progress Notes showed documentation that the Acute Care Plan interventions were consistently carried out as stated in the	

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		plans. ▪ Eleven of 12 (92%) Integrated Progress Notes documented that Acute Care Plans for Shigella were resolved. ▪ Eleven of 12 (92%) Acute Care Plans noted that the plans were resolved. ▪ Four of four (100%) records documented when individuals were sent to the emergency room and/or were hospitalized for Shigella; Nursing Protocol for Emergency/Hospital transfers were followed. The review of the 12 individuals' Acute Care Plans for Shigella and accompanying Integrated Progress Notes showed an overall compliance score of 96%. The Monitoring Team reviewed records for three cases of Urinary Tract of Infections for Individuals #33, #160, and #481, and found significant improvement in the individualization, comprehensiveness, and quality of the Acute Care Plans for Urinary Tract Infection. A review of the Acute Care Plans and accompanying Integrated Progress Notes showed: • One of one (100%) Integrated Progress Notes showed nurses followed the Nursing Protocol: "When contacting the PCP, document that you provided the following..." was followed when individuals' experienced an acute change of status related to Urinary Tract Infection (UTI). Two asymptomatic individuals were diagnosed based on urinalysis lab results for culture and sensitivities. • Three of three (100%) Acute Care Plans were initiated promptly upon diagnoses of UTI. • Three of three (100%) Acute Care Plans had baseline data sufficient to identify the rationale that led up to the necessity for care plans. • Three of three (100%) Acute Care Plans had goals sufficient to identify the desired outcomes of for which the care plans were design to resolve the UTIs. • Three of three (100%) Acute Care Plans were individualized sufficient to meet the individuals' health care needs for managing UTIs. • Three of three (100%) Acute Care Plans incorporated relevant protocols and physician orders for treatment, including Nursing Protocols for: Antibiotic Therapy, UTI, and Pain. • Three of three (100%) Acute Care Plans included how frequently interventions were to be completed, by whom, and where documented. • Three of three (100%) Acute Care Plans included DSP Instruction Sheets. • Three of three (100%) Acute Care Plans' DSP Instructions Sheets were individualized sufficient to meet individuals' health care needs for UTIs. • Three of three (100%) Acute Care Plans' DSP Instructions sheets contained documentation that DSPs were trained. • Three of three (100%) Integrated Progress Notes documented that Acute Care Plans for UTI were initiated. • Three of three (100%) Integrated Progress Notes documented that Nursing Protocol for: Antibiotic Therapy was consistently followed.	

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		• Two of three (67%) Integrated Progress Notes documented that Nursing Protocol for: UTI was consistently followed. • Two of two (100%) Integrated Progress Notes documented that the Acute Care Plans were resolved. One plan was still in progress. • Two of two (100%) Acute Care Plans noted that the plans were resolved. One plan was still in progress. • One of one (100%) record showed documentation when individuals were sent to the emergency room and/or were hospitalized because for UTI; Nursing Protocol for Emergency/Hospital Transfers was followed. The review of the three individuals' Acute Care Plans for UTIs and accompanying Integrated Progress Notes showed an overall compliance score of 98%. Although the Acute Care Plans for UTIs were clinically sufficient for managing care, documentation in the Integrated Progress Notes showed only two of three (67%) of the Nursing Protocols in Acute Care Plans for UTI was consistently followed. Over the next six months Nursing administration and the Infection Control Nurse should focus on ensuring that the nursing staff follows the UTI Nursing Protocol. The Facility's Self-Assessment stated they were in compliance with this Provision. Nursing Department had fully implemented the revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. The RN Case Manager Supervisor had put forth concerted effort in training the RM Case Managers and reviewing the completed Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessments. This Provision continued to be in substantial compliance. The ACPs were exemplary. This was evidenced in reviewing the recent and/or currently active ACPs for Reportable Communicable Diseases, Urinary Tract Infections, and Pressure Ulcers (reported in Provision M.1). Although the Acute Care Plans were clinically sufficient for managing care, documentation in the Integrated Progress Notes did not consistently show that the plans were carried out as designed (for example, the ACP for UTI). Over the next six months Nursing administration should focus on ensuring that the nursing staff consistently follow and document care provided as stated in the care plans. The positive practices found must be maintained, with a need to continue to demonstrate effective steps over time to make improvements when needed. Because compliance for nursing's admission and annual care plans is closely aligned with the requirements related to the IRRF and IHCP processes, this information is reported in Provision M.5. The Facility has made exemplary progress in planning and providing nursing interventions that are based on clinical data and on protocols to address a range of risks and health care conditions, and	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>that address identified high-risk health conditions, and that are individualized. To achieve substantial compliance, the Facility must maintain these improvements, provide greater specificity in IHCPs, and ensure and document consistent implementation of the actions in those plans.</td><td></td></tr>
<tr><td>M4</td><td>Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.</td><td><u>Monitoring Team Findings:</u>
The Monitoring Team validated the Nursing Education information presented in the Facility's Self-Assessment through: Review of the Nursing Education information presented in the Section M Presentation Book; and meetings/interviews with CNE, NOO, and Nurse Educator. Review of Nursing Training Database and supporting training documentation. Related Self-Assessment data were updated while onsite. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.4 and the Monitoring Team concurs with their findings.

On April 16, 2013, a new Nurse Educator was hired. The previous Nurse Educator provided orientation to the new Nurse Educator. According to interview with the new Nurse Educator and review of the training documentation there was no regression in nursing education.

<u>New/Revised State/Local Policies, Procedures, Processes, and Protocols:</u>
• DADS Policy Number: 010.3, Nursing Services, 6/17/13
• DADS Nursing Protocol: Hospitalizations, Transfers, and Discharges, Dated: March 2013
• DADS Nursing Protocol Cards: Five new Nursing Protocol Cards were added in May 2013 for: Suspected Fracture/Dislocation, Pain, Hypoglycemia, Emergency/Hospital Transfers, and Fall or Suspected Fall
• Brenham SSLC Guidelines: Nursing Required Training Topics and Training Materials for New Nurse Orientation and Annual Refresher Training, 7/26/13

<u>Training Activities:</u>
All annual refresher competency checks and New Nurse Orientation were based on the Nurse Educator Handbook approved by the state office. The Nurse Educator continued to maintain an excellent, comprehensive, and up to date Nursing Training Database that indicated the percentage of the nurses completing the required training. For nurses who had not completed the required training, the respective Nurse Managers, CNE, NOO, and respective nurses were notified and training was rescheduled.

Required training provided through the Nursing Education Department and percentage of completion for nurses that occurred over the past six months is reported in the chart below:

<table>
<tr><td>Title of Required Nurses' Training:</td><td>Percentage of Nurses Completing the Required Training</td></tr>
<tr><td>Annual refresher competency-based training according to the Nursing Education Handbook and BSSLC SSLC Nursing</td><td>100%</td></tr>
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</td><td>Substantial Compliance</td></tr>
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		Guidelines. Training included all incumbent nurses and agency nurses.		
		New Nurse Orientation according to the Nurse Educator Handbook and Brenham SSLC Guidelines. This is taught for all new nurses, including agency nurses.	100%	
		Nursing Protocol Card Training for all 23 Cards	100% (A set of 23 cards was provided to each incumbent nurse. The training on and issuing of Nursing Protocol Cards was included in New Nurse Orientation for all nurses, including agency nurses.)	
		State mandated Physical Assessment Class for Incumbent RN Case Managers and RNs. This class is now taught in New Nurse Orientation for all RNs.	98% (The remaining RNs who had not completed the class were on extended sick leave and will complete the next available class upon return.)	
		Mosby Class on the Chapter 13 for Chest and Lungs. This class will be taught to new RNs after completing the state mandated Physical Assessment Class.	97%	
		Mosby Class on the Chapter 14 for the Heart. This class will be taught to new RNs after completing the state mandated Physical Assessment Class.	98%	
		Mosby Class on the Chapter 17 for Abdomen. This class will be taught to new RNs after completing the state mandated Physical Assessment Class.	97%	
		Mosby Class on the Chapter 21 for Musculoskeletal. This class will be taught to new RNs after completing the state mandated Physical Assessment Class.	100%	
		Mosby Class on the Chapter 22 for Neurology. This class will be taught to new RNs after completing the state mandated Physical Assessment Class.	100%	
		Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulties. This class will be taught to new nurses, including agency nurses, after completing New Nurse Orientation.	100%	
		Revised Nursing Services Policy related to changes for MOSES/DISCUS assessments	89%	
		Review of Medication Variance Policy	83%	
		Plan of correction Related to Documentation of Antibiotics	83%	
		Death Review Recommendations for TM	98%	

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SOAP Documentation for LVNs	98%
Gastrostomy Tube Precautions for Stomas Less than Three Months Old	88%
Unusual Incident Report Recommendation to Review Proper Procedures to Process Physician Orders	85%
Death Review Recommendations for KK	100%
Clarification of Suicide Protocol	99%
Review of Seizure Protocol	99%
Interdisciplinary Team Actions for Enteral Nutrition	99%
Review of P.1 Habilitation Therapy Services, P.2 Physical Nutrition Management Plan, and R.1 Communication Services Policies	98%

It was positive for the Monitoring Team to find that all nurses observed during the tours in Bowie, Childress, Driscoll, Fannin, and Cottages, were visibly carrying their protocol cards, as required.

It was positive to find since the last compliance review, the Nursing Education Department had purchased and was using a complete Nursing Skills Manikin. The Nurse Educator showed the Monitoring Team the life size manikin that was interchangeable from female to male and explained the multiple skill features that it could be performed. The manikin can be used by nurses for practice and competency checks on head to toe physical assessments including visual assessments and a variety of procedures, such as, but not limited to: Intramuscular injection sites, ostomy care, tracheostomy care and suctioning, urinary catheterization, gastrostomy procedures, and positioning. In addition, the manikin was being used for practice during Emergency Equipment Checklist and Emergency Response competency check-off to simulate an actual code and use of emergency wagon and emergency equipment as part of the check-off. This included the use of AED, oxygen, ambu bag, and teamwork. It was positive to find that in an effort to enhance awareness of CPR procedures to parade participants during the Facility's recent Beach Bash Parade, the Nursing Administration staff dressed in white T-shirts with a red cross design and used the nursing education's manikin to simulate CPR.

In addition to the above uses for the Nursing Skills Manikin, documentation was provided that showed the manikin was used to train the home staff on care and management of Individual #444's recently place ileostomy, secondary to surgery for rectal cancer.

Additional training provided to nurses by the Infection Control Nurse and Skin Integrity Nurse is reported in Provision M.1. Training provided to RN Case Managers by the RN Case Manager Supervisor was reported in Provisions M.2, M.3, and M.5.

The degree of adherence to the nursing protocols was reported in the other appropriately related

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		Provisions. Care was consistent with protocols for vomiting, diarrhea, antibiotic therapy, and other conditions, assessment and documentation followed the protocols, and the requirements in various protocols for reporting to the medical practitioner were followed. Furthermore, the review of individuals' care did not reveal any significant inconsistencies with the protocols. The Facility's Self-Assessment stated they continued in substantial compliance with this Provision. The Monitoring Team concurs that this Provision continued in substantial compliance. As reported above, substantial compliance was demonstrated through the Monitoring Team's independent review of the Section M Presentation Book, staff interviews, observations of nursing care, and review of documents to verify that the Nursing Department had continued to maintain positive practices toward the development and implementation of nursing policies, procedures, processes, protocols and training.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Risk Management information presented in the Facility's Self-Assessment through: Review of the Risk Management information presented in the Provision M.5 section of the Presentation Book; review of documents requested; meetings/interviews with the CNE, Nursing Operations Officer, QA Nurse, and RN Case Manager Supervisor; attendance at an ISPA Post-Hospital Discharge Meeting; and review of individuals' medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in not substantial compliance with Provision M.5 and the Monitoring Team concurs with their findings. Since the last compliance review, the Facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes. The IRRF and IHCP processes were fully implemented at the time of the review. All new admissions, annual ISPs have transitioned to the new IRRF and IHCP processes. Facility's Self-Assessment stated, "The Annual Nursing Care Plan Monitoring Tool had showed a quarterly 72% in July and a quarterly 79% in October. Based on these results, on 8/8/2013, the Case Managers were retrained on the process with 100% completing the training. Improvement has been made since the training. The Case Manager Supervisor will follow up with corrective action as needed. Comparison of Nursing/QA Inter-Rater Reliability Tracking and Trending for Annual Nursing Care Plans shows 70% in July. This process has changed due to the implementation of the IHCP. It was noted that Section M Monitoring Tool regarding care plans was not effective in measuring the new IHCP process." The Monitoring Team reviewed five of the recently Integrated Risk Rating Forms and Integrated Health Care Plan Forms provided in the document request for Individuals #153, #258. #431, #591, and #251, and found: • Zero of five (0%) identified significant changes in some of the risk rating categories since the last	Noncompliance

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		review. • Four of five (80%) had comprehensive interdisciplinary assessment completed. • Four of five (80%) risk assessments provided clinical data sufficient to accurately determine risk levels. • Four of five (80%) risk assessments sufficiently provided information that helped to develop a plan to address risk ratings. • Five of five (100%) IHCPs indicated they were approved and implemented by the IDTs within 14 days. However, from reviewing documents in individuals' active record it was difficult to determine the dates the plans for all identified risk ratings were actually implemented. • Three of five (60%) IHCPs were clinically sufficient to meet the needs for all identified risk ratings. • Five of five (100%) IHCPs included preventative interventions to minimize all of the identified risk ratings. • Three of five (60%) IHCPs were sufficiently integrated among all appropriate disciplines. • Two of five (40%) changes were made in individuals' services and supports for all identified risk ratings. • Three of five (60%) IHCPs contained functional and measurable objectives in the ISPs to measure efficacy of the plans. However, most were generic and should have been more specific to the risk ratings and individuals. • Three of five (60%) IHCPs identified appropriate clinical indicators to be monitored and the frequency of monitoring. Examples: o Individual #151's IHCP did not reflect the all information identified in the IRRF. The Dietitian did not attend the ISP meeting. Individual #151 was on a no salt diet and was to have free excess water to prevent dehydration. The Dietitian should have assisted the team to determine the amount of free water necessary to prevent dehydration without fluid overload. There was no plan to measure his intake and output. He was on Lithium with mild kidney damage secondary to the Lithium. Ensuring adequate hydration is essential for Individual #151. The blood pressure measurement indicated it was within normal range. Specific baseline blood pressure measures should have been included for future reference. Overall the IRRFs showed improvement, but the IHCPs were brief and lacked substantive information for the plans' interventions. The Facility should focus on ensuring that the IDTs continue to exercise clinical judgment in correlating the interrelatedness of areas of risks within the risk group, as well as between the various risk groups. There also was wide variation from unit to unit, and within the IDTs in the formats used for ISPs, IRRFs, and IHCPs, as well as the quality of the clinical data used to support the risk ratings. The Facility needs to ensure consistency across all IDTs, as well as among disciplines, if compliance is to be achieved regarding the IRRFs and IHCPs processes.	

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		The Monitoring Team agreed with the Facility's Self-Assessment findings regarding monitoring the Annual Nursing Care Plans due to changes in the IHCP process. Therefore, in reviewing the five recently completed IRRFs and IHCP it was not possible to accurately determine the degree of compliance with regard to the identification of nursing problems/diagnoses and the nursing care plans related to individuals' high and medium risk rating. Neither was it possible to identify other nursing problems/diagnoses that that may require nursing care plans that were not rated as high and/or medium risks. Some of the difficulties encountered in attempting to accurately determine compliance with nursing's responsibilities regarding the IHCP included: • New admission and annual nursing assessments were completed before the IDT finalized the IRRFs and IHCPs. Therefore, the nursing problems/diagnoses and nursing related responsibilities of the assessment were not yet completed. It would not be until the first Quarterly Nursing Record Review/Quarterly Physical Assessments were completed that the determination for compliance with this requirement could be made. • The former HMPs were replaced by the IHCPs. In reviewing the Annual Comprehensive Nursing Assessments' Section IX Nursing Problems/Diagnoses and Section X Nursing Summary/Analysis, these items were not included in the recently completed annual assessments for individuals previously identified with nursing problems/diagnoses and HMPs. Therefore, it was not possible to determine compliance with the requirement for identifying nursing problems/diagnoses and whether health care plans were implemented for them or what individuals' health status were in response to the health care plans and their effectiveness. Refer to Section I for additional information regarding compliance with the IRRF and IHCP processes. Based on the review of the above individuals' IHCPs associated with nursing's responsibilities for the identification nursing problems/diagnoses, development of associated care plans, and progress toward stated goals, and the effectiveness of the plans, more experience needs to be gained with the use of the IHCPs before accurate substantial compliance can be determined.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional	<u>Monitoring Teams Findings:</u> The Monitoring Team validated the Medication Administration information presented in the Facility's Self-Assessment through: Review of the Medication Administration information presented in the Provision M.6 section of the Presentation Book; review of documents requested; meetings/interviews with the Chief Nurse Executive, Pharmacy Director, Clinical Pharmacist, Medical Director, QA Director, QA Nurse, Program Compliance Nurse, and Nurse Managers; attendance at the Pharmacy and Therapeutics Committee Meeting; inspections/observations of units' Medication Rooms; Review of Units' Medication Administration Record Notebooks; and conducted Medication Administration Observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6 and the Monitoring Team concurs with their findings.	Substantial Compliance

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	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.	Medication Variance Policies and Procedures: • DADS Procedure: Medication Administration Observation Guidelines (draft), June 2013 • BSSLC Policy N.12 Pharmacy Services and Safe Medication Practices, Medication Variances 6/5/13 • BSSLC Policy N.13 Pharmacy Services and Safe Medication Practices, Destruction of PHI Material 6/5/13 Training Activities: • Medication Administration for Individuals with Dysphagia and/or Swallowing Difficulties was completed by 100% of the incumbent nursing staff responsible for medication administration. This class will be taught to new nurses, including agency nurses, after completing New Nurse Orientation. • BSSLC Policy N.12 Pharmacy Services and Safe Medication Practices, Medication Variances was taught to all new Facility and agency nurses during orientation. Medication Variance Committee Meetings: • Of the monthly Medication Variance Committee Meetings scheduled, six of six (100%) occurred as scheduled. The meetings were well attended by the core membership. • The Monitoring Team reviewed the monthly Medication Variance Committee Meeting minutes for May 2013 through September 2013, and attended the Medication Variance Committee Meeting on October 9. 2013. The Committee continued to be chaired jointly by the Pharmacist Director and Nursing Operations Officer. The committee continued to analyze and trend monthly and quarterly Medication Variance Data Reports by: department, severity levels, types of medication variances, classification of medications, and contributing factors for Units/Cottages, homes, shifts, and facility-wide. In addition, monthly Medication Observation, Medication Administration Record Audits, and Medication Room Audits were reported at the meetings. Copies of the Unit Nurse Medication Variance Reports and local and systemic plans of correction were submitted. This information was attached to the minutes. It was positive to find that the Director for Behavioral Service had become a member of the committee. Any medication variances, omission/extra doses related to psychoactive medication were reported to her to follow-up for changes in behaviors. She reported that one individual had missed some psychoactive medications and as a result the individual's behaviors improved. Then, the individual's medications were adjusted down with positive results. Pharmacy and Therapeutics Committee Meetings: The Monitoring Team reviewed the Pharmacy and Therapeutic Committee Meeting Minutes for July 25, 2013 and attended the Pharmacy and Therapeutic Committee Meeting on October 10, 2013. The findings from the Medication Variance Committee Meeting continued to be reviewed and discussed at the quarterly Pharmacy and Therapeutic Committee Meetings. The Infection	

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		Control Nurse continued to present the Antibiogram at the Pharmacy and Therapeutics Committee meetings regarding the sensitivity/susceptibility of antibiotics prescribed for specific organisms. The Antibiogram was updated annually as opposed to every six months, since it was found there were no significant changes within a six months period. Refer to Provision N.8 for additional information regarding the Pharmacy and Therapeutic Committee Meetings. <u>Medication Variances Reported:</u> The Facility continued to maintain an excellent Medication Variance Database to record, track, analyze, trend, and report data. Reported Medication Variance data included variances by: Severity Index Classifications, type of variance, type of medication, department, Unit/Cottage and by each home responsible for the variance, by individual, and type of medication for which the variance occurred. The reports also included monthly ratios of medication variance to total doses of medication administered. The Medication Variance Database reported variance data monthly, quarterly, and longitudinally. Medication variance data reported was presented in tabular, graphic, and narrative forms.	

Medication Variances by Disciplines – April 2013 through July 2013

Month/Year	April 2013	May 2013	June 2013	July 2013	August 2013
Other*	4	N/A	N/A	N/A	N/A
Pharmacy	10	10	6	9	8
Nursing	85	152	162	124	118
Medical	8	16	10	8	6
Dental	0	0	0	0	0
Total	107	178	178	141	132

Other* not specified.

There was approximately a 73% increase in medication variances committed by nursing in May and June 2013. The increases, which were primarily due to documentation variances where the medications administered were not initialed on the Medication Administration Records, were attributed to newly hired nurses and agency nurses. Although medications were reconciled, Medication Variance Reports were completed when the Medication Administration Records were not initialed and the nurses counseled/retrained upon discovery of the variance. The RN Shift Manager retrained all of the incumbent agency nurses on safe medication administration practices and provided onsite observations until the agency nurses' demonstrated competency. The newly hired agency nurses now attend the same medication administration competency-based training as other newly hired Facility nurses. The CNE stated that the eight new LVNs hired from another state had not administered medications as part of their licensure. Therefore, these nurses were provided intensive training in medication administration and assigned a preceptor to assist them during medication administration until they achieved competency. As result, there was a progressive

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		decrease in medication variances in July and August 2013. The medication variance data for September 2013 was not yet available for review. The Pharmacy used a triple check system when dispensing cart refills. The nurses on the units also check cart refills for accuracy. Daily at the change of shifts the oncoming and off going nurses check the Medication Administration Records against the medications in the medication carts, reconcile any problems identified, and completed a Medication Variance Report for any unreconciled medications. The nurses' sign a Medication Record Review Sheet to validate the checks were completed. The Nurse Managers and QA Nurse conducted Medication Administration Record Audits, as described below. It was positive to find that the Pharmacy and Nursing Departments had continued to tighten controls in an effort to catch medication variances, which increased accuracy of identifying variances and might partly explain the increased number of medication variances reported. <u>Completion of 10 Most Recent Medication Variance Reports:</u> The Monitoring Team reviewed ten of the most recently completed Medication Variance Reports for Individuals #34 #490, #205, #570 (two reports), #536, #243, #248, #75, and #400. Findings include: • The Medication Variance forms were fully completed, and indicated the type of variance, severity index, physician notification, and review by the department supervisor, in ten out of ten (100%) examples. • The department supervisor documented appropriate corrective action in ten out of ten (100%) examples. • Nursing Administration reviewed the Medication Variance Reports before they were entered into the Medication Variance Database for any corrections and further corrective action when indicated. • Medication variances were incorporated into the medication variance database and after analysis and were presented to the Medication Variance Committee for review in ten out of ten (100%) examples. In July 2013, the Nurse Managers or RN designees began entering the Medication Variance Reports into AVATAR. The home nurses continued to fill out paper copies and gave them to the Nurse Managers/designees to enter into AVATAR. Copies were also given to the QA Nurse who entered the information into the old database until any problems with AVATAR were resolved. <u>Self-Audits for Medication Administration Observations, Medication Rooms, and Medication Administration Records:</u> Nursing Administration and the QA Nurse continued to conduct Medication Administration Observations, Medication Rooms, and Medication Administration Records as described below: • Medication Administration Record (MAR) Audits: o The Nurse Managers conduct audits on five individuals' MARs from each home every week.	

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- The QA Nurse conducts audits on every MAR on every home once a month.

- Medication Room Audits:
  - The Nurse Managers conduct audits on one medication room every week, except for the Cottages where two medication rooms are audited every week.
  - The QA Nurse audits the control drug count for completeness, accuracy and security, the security of medication room, equipment check log, and temperature log on every home once a month.
- Medication Administration Observations:
  - The Nurse Managers conducted Medication Administration Observations quarterly on each nurse for one year. Nurses who scored 90% or above for four consecutive observations were only observed twice per year. For new nurses and/or nurses who had a score of less than 90%, they continued on quarterly observations, or more often at the discretion of the Nurse Manager.
  - The QA Nurse conducted medication observation quarterly for inter-rater reliability checks.

The Monitoring Team reviewed the Medication Administration Observations, Medication Rooms, and Medication Administration Records audit data reported in the Facility Self-Assessment, along with supporting documentation provided to validate the information reported. The chart below shows the overall results of these audits, April 2013 through July 2013. The audit results for August 2013 and September 2013 was not yet available for review:

Medication Administration Observations, Medication Rooms, and Medication Administration Records, April 2013 through July 2013

Audits Completed	April 2013	May 2013	June 2013	July 2013
Medication Administration Observations	100%	100%	100%	99.2%
Medication Administration Record	99%	95%	92%	98%
Medication Room	100%	99%	98%	98%

Overall none of the above audits fell below 90% compliance. However, the Monitoring Team's review of the individual unit's monthly audit reports and accompanying plans of correction showed when local deficiencies were identified, that corrective action was taken even though the unit's overall score was 90% or above.

While onsite, the Monitoring Team accompanied the NOO, Nurse Manager for the unit, and RN Shift Supervisor, and inspected the Medication Room and Medication Administration Record Note Books, in Bowie, Childress, Fannin, and Cottage B. Using the standardized Medication Room Audit Tool, the findings of the inspection of the medication rooms was consistent with the Facility's audit results, i.e., Fannin 100% compliance, Childress 100% compliance, Cottage B 100%, and Bowie A 93%. The 93% compliance in Bowie A was due to an opened, undated, and uncovered can of Jevity found in the

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		refrigerator, which was removed and disposed of immediately. The Nurse Manager's investigation and corrective action upon discovery of the open can showed that the nurse responsible was a new LVN in orientation, who was retrained on the spot. The Medication Administration Records Notebooks were reviewed in the same areas. All requirements were met with the exception of two medication variances found in Cottage B at the 2000 (10 pm) medication pass on 10/7/13. The Nurse Manager immediately investigated the medication variances. Medications were reconciled and it was found that they were given. The nurse forgot to initial a few of the medications administered on the MAR. The Nurse Manager completed two Medication Variance Reports and retrained the nurse responsible. The Monitoring Team was provided copies of the Medication Variance Reports that validated appropriate corrective action was taken by the Nurse Manager. <u>Monitoring Team's Medication Administration Observations:</u> The Monitoring Team conducted medication administration observations, for oral and/or enteral routes in Childress, Cottage B, and Bowie A and B, and findings included. General observations: • All individuals observed who required a PNMP, had a current PNMP with strategies for medication administration. • All individuals who required specific adaptive equipment had it available on the medication carts. The adaptive equipment was properly sanitized per Facility policy. • The nurses administering medications consistently referred to and followed individuals' PNMPs, such as, texture, how pills were to be administered, presentation techniques, required adaptive equipment, positioning equipment and their stated use. • The nurses administering medications consistently followed generally accepted safe medication administration practices for oral and enteral routes of administration. • Individuals were told the name of the medications and their purpose, with rare prompting by the Nurse Managers for newly hired nurses. • Individuals were provided privacy during medication administration, either in a private room or shielded with privacy screens. • The DSP staff consistently assisted the nursing staff by bringing one individual at a time to receive medications. • Individuals who had Self-Administration of Medication Programs were reinforced. Specific observations: • It was positive to find improvements in nurses' implementation and specific strategies for administering medications according to their PNMPs. For example: o In Cottage B, the nurse was administering medications to an individual who started to hyperextend his head and neck when swallowing medications. The nurse asked him to look at her and he did so; this prevented the hyperextension that could have put the individual at risk for aspiration. o Another individual in Cottage B was prescribed nectar-thickened liquids with pills given	

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		whole a few at a time mixed in pudding. While attempting to swallow a few pills mixed with pudding (of which one was a large calcium pill), followed by attempting to drink the nectar-thickened liquid, he then coughed a couple of times without struggle. The individual was immediately assessed by an RN according to the Respiratory Distress/Aspiration Protocol with no abnormal findings documented in the Integrated Progress Notes. The individual was referred to Habilitation Therapy for a medication observation to evaluate the size and texture of the pills administered. The Monitoring Team was provided Integrated Progress Notes and a copy of the referral to Habilitation Therapy to validate the actions taken. It was positive to find that several improvements were made regarding the administration of medications. Improvements included: The antiquated medication carts were being replaced a few at a time. New medication cards were observed in Childress, along with a lock box and new procedure for securing medication keys. The medication carts observed in Fannin appeared to be the most antiquated; they had extremely limited space on top for which to place supplies for administering medications. Cottage C was under renovation so that it will have a larger medication room. This Provision continued to meet substantial compliance. The positive practices found must be maintained, with a need to continue to demonstrate effective steps over time to mitigate medication variances. Further, the positive medication administration practices and medication variances procedures and processes demonstrated by this Facility are exemplary to their peers and should be recognized as such. Refer to Provision N.8 for additional information regarding medication variance.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment 9/23/2013 2. BSSLC Action Plan 9/19/2013 3. BSSLC Pharmacy Services and Safe Medication Practices; Adverse Drug Reaction policy, revised 10/10/2013 (unnumbered) 4. Pharmacy and Therapeutics (P&T) Committee meeting minutes for 7/25/2013, and 10/10/2013 5. All medication variance committee meeting minutes completed during the review period 6. For Individuals #233, #347, #97, #566, #26, #567, #347, #86, #33, and #417: a. Pharmacy documentation of review for allergies, interactions, required diagnostics, appropriate indication, and dose b. Past six months laboratory data c. Current medication list d. EKG for past three years e. Most recent ophthalmology report f. Completed SPDI (single patient drug intervention reports) associated with the new medication order 7. QDRR schedule for past six months, and pending six months 8. List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date 9. Average daily census 10. Alpha list of individuals who were prescribed a neuroleptic and have diabetes 11. Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension 12. Alpha list of individuals who were prescribed a benzodiazepine 13. Alpha list of all individuals with diagnosis of osteoporosis 14. Alpha list of all individuals with diagnosis of seizure disorder 15. For individuals #403, #223, #483, #41, #519, #570, #140, #45, #404, #27, #189, and #81: a. Most recent two QDRRs b. Past six months MOSES and DISCUS assessments c. Most recent 12 months of lab results d. Most recent two EKG reports e. Most recent annual physician summary f. Most recent psychiatric assessment g. Most recent Integrated Risk Review Form (IRRF) h. Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale 16. Data analysis, and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use

	17. For Individuals #367, #1, #270, #582, #255, #539, #554, #43, #159, and #35: a. Most recent two QDRRs b. Most recent IRRF c. Current medication list d. Most recent psychiatric assessment e. Most recent annual medical assessment 18. For Individuals #305, #133, #243, #403, #488, #152, #24, #10, and #300: a. Most recent QDRR b. Most recent IRRF c. Current medication list d. Most recent six months laboratory data e. Most recent annual medical assessment f. Most recent psychiatric assessment g. Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome 19. Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties 20. Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties 21. Alpha list of individuals who are prescribed anticholinergic drugs 22. For the first ten individuals on the list of individuals prescribed anticholinergic drugs (Individuals #96, #413, #189, #332, #133, #205, #89, #331, #59, and #492) a. Most recent two QDRRs b. Current medical list c. Most recent medical, and psychiatric annual reviews d. Most recent MOSES and DISCUS assessments 23. Psychotropic Medication Oversight Committee (PMOC) meeting minutes for 4/2013 through 10/2013 24. List of all individuals on polypharmacy 25. For the first, and than every second individual on the list of polypharmacy, for a total of ten individuals (Individuals #367, #1, #471, #248, #582, #167, #439, #61, #19, and #75): a. Most recent two QDRRs b. Most recent psychiatric assessment c. Current medication list d. Most recent ISP, or related document the use of polypharmacy 26. For Individuals #133, #120, #159, #493, #19, #568, #508, #93, #270, #53, #570, and #206: a. SPDI (single patient drug intervention) report b. Copy of associated medication order c. Documentation of pharmacist's review of the order d. Clinical evidence for the medical provider following up on the recommendation, or alternative rationale 27. All MOSES and DISCUS assessments completed during the review period for Individuals #579, #144, #159, #250, #152, #42; #243, and #417 28. ADR reporting forms for Individuals #444, #159, #148, #68, and #422

	29. Drug Utilization Evaluation (DUE) schedule 30. Copy of all DUEs completed during the reporting period 31. Medication Variance Committee meeting minutes, for 5/2013 through 9/2013 32. All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances 33. List of all medication variances that occurred during the reporting period 34. For the first, and than every second individual listed on the medication variance list (for a total of ten examples): a. Copy of completed medication variance report form b. All physician IPNs associated with the medication variance c. All nursing IPNs associated with the medication variance d. All pharmacy documentation, and communication related to the mediation variance e. All IDT minutes specific to the medication variance f. Documentation that the guardian/Legally Authorized Representative (LRA) was notified of medication variance of category C or worse **People Interviewed:** 1. Trey Knittel, PharmD, RPh (Clinical Pharmacist) 2. Robin Blankenburg, RPh (Pharmacy Director) **Meeting Attended/Observations:** 1. Medication Variance Committee Meeting
	Although the Facility is collecting data elements for its self-assessment, the Monitoring Team has concern that the Facility is not assessing relevant data. For Provision N.2, the Facility reported that QDRRs were completed on-time, 100% of the time, and did not identify the significant delays that had occurred between February 2013 and June 2013. Furthermore, the self-assessment did not address issues related to the adequacy of QDRRs,; for example, the self-assessment did not review if the pharmacist commented on the efficacy of prescribed medications, and did not assess if clinically relevant recommendation were document by the pharmacist for the medical providers consideration. For Provision N.3, the Facility reported that 100% of the samples indicated that medication risks were appropriately addressed. The Monitoring Team concurred with the Facility self-assessment for Provision N.4, indicating that the medical providers had addressed the pharmacist's recommendations; however, there was no assessment to determine if the pharmacist provided all necessary and relevant clinical recommendations to the medical provider. For Provision N.5, the Facility indicated that 100% of the sample indicated that individuals were appropriately monitored for drug side effects. the Monitoring Team noted, however, that only 80% of the ten examples reviewed indicated more frequent monitoring of side effects when clinically indicated. The self-assessment did not specifically assess if enhanced monitoring of drug side effects was provided when clinically necessary.

	For Provision N.6, the Facility reported that 100% of all ADRs reported were investigated by the pharmacist, and that the pharmacist developed recommendations for each ADR. The Facility did not provide evidence to the Monitoring Team of the pharmacist's follow-up or recommendations for ADRs. Also, the Facility did not assess the timeliness of reporting ADRs. For Provision N.7, the Monitoring Team concurs with the self-assessment, and the data elements assessed for this provision. The Monitoring Team concurs with the ratings of substantial compliance for all provisions of this section.
	Summary of Monitor's Assessment: The Monitoring Team determined that the Facility continues substantial compliance for all provisions of Section N. Furthermore, the Monitoring Team noted during the visit that the pharmacy continued to make worthwhile improvements in processes that had already been found in compliance with the requirements for the provisions. The Monitoring Team identified, however, that further enhancement would be required to maintain compliance at future reviews. For example, the Facility must enhance its identification and reporting of adverse drug reactions more timely. Additional, and more specific comments are as follows: **Provision N.1:** Because all new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.1. **Provision N.2:** The Facility continues to produce exceptional QDRRs. Despite falling behind with scheduled QDRRs for the first and second quarter due to a temporary staffing shortage, the Facility had completely caught up with all QDRRs; furthermore, the Facility developed and implemented a process that included training of all pharmacists on how to complete QDRRs, so in the event of a staffing shortage in the future, all pharmacists will be enabled to help ensure that the Facility remains current with the QDRRs scheduled. The Monitoring Team did note that the Facility started using the electronic format for the MOSES and DISCUS assessments, and in three examples the medical provider had not completed the comment and assessment sections. The Monitoring Team will expect that all MOSES and DISCUS assessments be fully completed at subsequent reviews, and that the QDRRs will be completed as scheduled for each quarter. The Monitoring Team is assessing QDRRs to ensure that the pharmacists document the clinical appropriateness and effectiveness of prescribed medications, and strongly recommends that for future reviews, the pharmacist provide a statement documenting the appropriateness and effectiveness of prescribed medications. In conclusion, the Monitoring Team continues to be impressed with the overall completion of QDRRs, and determined that the Facility is in substantial compliance with Provision N.2. **Provision N.3:** The Facility continued to ensure that metabolic syndrome, polypharmacy, anticholinergic, and benzodiazepine usage is addressed when completing QDRRs and ensured that regularly scheduled systems review of benzodiazepine, anticholinergic, and polypharmacy usage is reviewed through relevant

	committee structure, and for these reasons the Facility remains in substantial compliance. Beginning with this review, the Monitoring Team began assessing to ensure that appropriate dosage, clinical rationale, alternative pharmacotherapy, efficacy of pharmacotherapy, and pharmacotherapy risks be documented on the QDRR, and strongly recommends the pharmacy department ensure that the pharmacist address each of these issues on subsequent QDRRs. **Provision N.4:** The Facility continues to ensure that medical provider's review, and appropriately follow-up on pharmacy recommendations. The Facility remains in substantial compliance with Provision N.4. **Provision N.5:** The Facility demonstrated enhanced monitoring of tardive dyskinesia in 80% of the examples assessed, and substantial compliance is continued. The Monitoring Team recognizes that the Facility had recently implemented an electronic version of the MOSES and DISCUS assessments, and these assessments did not include documentation of the medical provider's completion of the assessments. For future reviews, substantial compliance will require that all MOSES and DISCUS assessments be fully completed by the medical provider, and that evidence indicating that all individuals who have either been started on a new neuroleptic, or prescribed a dose increase of a neuroleptic, be provided enhanced monitoring for tardive dyskinesia. **Provision N.6:** The Facility maintains an ADR reporting process and reported a total of six ADRs during this review period. There was evidence to indicate that all relevant staff had been trained on reporting ADRs. The Monitoring Team was concerned over the lack of reporting of ADRs from staff other then the clinical pharmacist. Also, it was apparent that only one out of five examples (20%) was reported at the time of the clinical manifestation of the ADR, and in most cases, the ADR reporting form was completed retrospectively by the clinical pharmacist. The Monitoring Team will continue compliance at this time; however, at future reviews, the Facility must ensure more timely reporting of ADRs by staff. It is also recommended that the ADR reporting form more clearly documents clinical follow-up to the ADR by the medical provider, and specific clinical recommendations by the pharmacist. **Provision N.7:** The Facility maintained a process for providing clinically relevant DUEs, and provided four DUEs during the reporting period. The DUEs provided clinically relevant information, and provided medical providers and pharmacists with information to enhance clinical practice. The Facility provided DUEs for two FDA advisories; however, because the Facility did not administer olanzapine pamoate or oral ketoconazole at the time of the FDA advisory, the Facility did not provide a formal DUE or other form of in-service to medical providers for these two drugs. Both oral ketoconazole and olanzapine pamoate are commonly used medications in the community, and although the Facility may or may not have individuals currently one such medications, it is important that the medical providers, and pharmacists are provided information on these important advisories, to keep providers current on such medications, as that information may influence their prescribing practice in the future. Substantial compliance will be continued at this time. The Monitoring Team strongly recommends that for FDA advisories for specific classes of drugs that are commonly used in general medicine and psychiatry, the Facility ensure that medical providers and pharmacists are provided a DUE, or alternative in-service training, for the advisory.

	Provision N.8: Because the Facility maintained a medication variance process that promptly addressed all reported medication variances, tracked and trended prescribing, documenting, dispensing, administering, storage of medication variances; and because nursing, pharmacy and medical leadership participate in the medication variance process, the Monitoring Team continued substantial compliance at this time. Compliance at future reviews will require that all departments, including medical services, ensure documentation of action steps taken for reported medication variances. The Monitoring Team strongly recommends that the Facility develop a specific section on the medication variances committee minutes, for all newly developed action plans, and a section for follow-up to action plans. In addition, the Facility should also ensure a process that documents the pharmacist's review of each medication variance, and when clinically appropriate, provides clinical recommendations.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	Provision N.1 requires that a pharmacist reviews all new medication orders to ensure that the medication is for a clinically appropriate indication; evaluate all diagnostics necessary for safe administration of the medication; evaluate efficacy of the drug; ensure that the dose is clinically appropriate; and ensure that there were no contraindications, such as allergies, and drug-drug interactions. The pharmacist also utilizes the WORx, drug safety computer program, when reviewing all medication orders. The WORx program is an automated process that assesses for possible drug-drug interactions, known allergies, and prompts the pharmacist to review necessary diagnostics. To document the pharmacist's review of new medication orders, the pharmacist completes a checklist, which is stamped on each new medication order. The stamp includes notation for appropriate indication, evaluation of labs, assessment for allergies, and dose. To assess continued compliance with Provision N.1, the Monitoring Team reviewed copies of the last two medication orders of each month, for April 2013 through August 2013, for a total of ten new medication orders. In addition, the following information was reviewed for each example provided (Individuals #233, #347, #97, #566, #26, #567, #347, #86, #33, and #417) • Pharmacy documentation of a review for allergies, interactions, required diagnostics, appropriate indication, and dose • Past six months laboratory data • Current medication list • EKG for past three years • Most recent ophthalmology report • Completed SPDI (single patient drug intervention reports) associated with the new medication order	Substantial Compliance

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		The following is a summary of the Monitoring Team's review: • The pharmacist reviewed all new medication orders for potential allergies, interactions, appropriate doses, necessary diagnostics, and indications in ten out of ten examples (100%). • The Monitoring Team reviewed the medication order for potential drug interactions with the medication listed on the current medication list, and in ten out of ten examples (100%), the Monitoring Team identified no evidence of drug-drug interactions. • There were three examples requiring the initiation of a SPDI (Individuals #97, #567, and #86) and in three out of the three examples (100%) there was evidence to indicate that the medical provider appropriately addressed the SPDI by the pharmacist. • When clinically indicated, necessary laboratory diagnostics, EKGs, and consultations were obtained in ten out of ten examples (100%). Conclusion Because all new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.1.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	To assess that the Facility conducts quarterly drug regimen reviews (QDRRs), that are consistent with generally acceptable standard of care practice, and that the QDRRs are completed within the Facility's 14 day window for scheduled completion of QDRRs, the Monitoring Team reviewed the following documents: • QDRR schedule for past six months, and pending six months • List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date • Average daily census • Alpha list of individuals who were prescribed a neuroleptic and have diabetes • Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension • Alpha list of individuals who were prescribed a benzodiazepine • Alpha list of all individuals with diagnosis of osteoporosis • Alpha list of all individuals with diagnosis of seizure disorder • The Monitoring Team selected the following examples from the alpha lists of individuals with seizure disorder (Individuals # 403, #223, #483, #41, #519, #570, #140, #45, #404, #27, #189, and #81 o Most recent two QDRRs o Past six months MOSES and DISCUS assessments	Substantial Compliance

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		o Most recent 12 months of lab results o Most recent two EKG reports o Most recent annual physician summary o Most recent psychiatric assessment o Most recent IRRF o Evidence that the medical providers reviewed the pharmacists recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale <u>Timely Completion of QDRRs</u> Per the documents entitled QDRR Production and Discussion, the Facility self-reported that because of the transition of the past pharmacy director to the position of the clinical pharmacist, and the training of a new pharmacy director, the Facility had experienced a significant delay in timely completion of quarterly QDRRs; however, as of 8/22/2013, the 266 delinquent QDRRs were completed, and per review of the quarterly QDRR schedule, all current QDRRs were completed as scheduled, at the time of this review. Subsequently, the Facility provided the Monitoring Team with a pharmacy procedure entitled Staffing Guidelines for Timely Completion of Quarterly Drug Regimen Reviews, which outlined a new process that enables staff pharmacists the ability to complete QDRRs, in the event of a future staffing shortage. The Monitoring Team considers this a temporary failure to comply during a period of otherwise sustained compliance. The Facility recognizes that at future reviews, the Facility must ensure that QDRRs are completed within the scheduled timeframe. The following is a summary of the Monitoring Team's findings of the document review for the selected sample (Individuals #403, #223, #483, #41, #519, #570, #140, #45, #404, #27, #189, #81): • Of the 23 examples, there were ten instances of polypharmacy, and in ten out of ten examples (100%), the pharmacist addressed polypharmacy. • For the two individuals treated with benzodiazepines, two out of two (100%) examples indicated a specific assessment for the use of benzodiazepine by the pharmacist. • The pharmacist assessed Laboratory and other diagnostics, such as EKGs and DEXA scans in 11 out of 12 examples (92%). Individual #189 was on three medications for osteoporosis and DEXA results were not assessed by the pharmacist. • Metabolic syndrome was appropriately assessed in three out of the three examples (100%) that required a review for metabolic syndrome. • The Monitoring Team began at this visit to assess whether the QDRR indicated	

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		review by the medical provider. The QDRR indicated review by the medical provider in 12 out of 12 examples (100%). • The QDRR indicated review by the psychiatrist in three out of the three examples (100%) of the QDRRs that required review by the psychiatrist. • The completed MOSES and DISCUS were included as part of the assessments for the QDRRs in 8 out of 12 (67%) examples. There was no MOSES provided for Individual #404, and the QDRR documented that "does not require MOSES". Also, the MOSES and DISCUS assessments for Individual #570 dated 8/21/13 was an electronic form, that did not include comments by the medical provider. The MOSES dated 9/20/13 for Individual #189 was an electronic form document that did not include comments by the medical provider; The MOSES dated 8/29/13 for Individual #81 was an electronic form document that did not include comments by the medical provider. Assessments must be signed, and completed by the medical provider. • The IRRFs reflected side effects in 12 out of the 12 examples (100%). • By review of the annual medical assessment, clinical laboratory data, clinical consultations, and other diagnostics, the Monitoring Team concurred with the pharmacists that no specific recommendations were required on 12 out of 12 QDRRs (100%). • When assessing osteoporosis, the pharmacist: o Commented specifically on the appropriateness of treatment in three out of three examples (100%). o Commented specifically on the efficacy of treatment for osteoporosis in one out of three examples (33%). • The QDRR clearly delineated effectiveness of all drugs prescribed in zero out of 12 examples (0%) <u>Conclusion</u> The Facility continues to produce exceptional QDRRs. Despite falling behind with scheduled QDRRs for the first and second quarter, the Facility had completely caught up with all QDRRs; furthermore, the Facility developed and implemented a process that included training of all pharmacists on how to complete QDRRs, so in the event of a staffing shortage in the future, all pharmacists will be enabled to help ensure that the Facility remains current with the QDRR scheduled. The Monitoring Team noted that the Facility had regressed with regard to timely completion of QDRRs, which was secondary to staffing issues. All QDRRs were up to date by the time of this review, and the Facility had developed a robust remediation process that will prevent delays in timely completion of QDRRs in the future. The Monitoring Team considers this a temporary failure to comply during a period of otherwise sustained compliance.	

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		The Monitoring Team began at this visit to consider whether the QDRR indicated review by the medical provider. This occurred in most cases, but this must become more consistent at future reviews. The Monitoring Team noted that the Facility started using the electronic format for the MOSES and DISCUS assessments, and in three examples the medical provider had not completed the comment and assessment sections. The Monitoring Team will expect that all MOSES and DISCUS assessments be fully completed at subsequent reviews, and that the QDRRs will be completed as scheduled, for each quarter. The Monitoring Team is assessing QDRRs to ensure that the pharmacist documents the clinical appropriateness, and effectiveness of prescribed medications, and strongly recommends that for future reviews, the pharmacist provide a statement documenting the appropriateness and effectiveness of prescribed medications. In conclusion, the Monitoring Team continues to be impressed with the overall completion of QDRRs, and determined that the Facility is in substantial compliance with Provision N.2.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Provision N.3 requires that the Facility evaluate its process and usage of stat emergency medications, polypharmacy, benzodiazepines, anticholinergics, and metabolic syndrome. The following is the Monitoring Team's review of Facility's processes for monitoring these medication related issues: <u>Benzodiazepine usage:</u> The Monitoring Team requested the following documents to review the Facility's review of benzodiazepine use: • Alpha list of all individuals on benzodiazepine • Data analysis, and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use • For the first five individuals on a list of benzodiazepines used for psychiatric indication, and first five individuals on a list of benzodiazepines used for neurological indication: o Most recent two QDRRs o Most recent IRRF o Current medication list o Most recent psychiatric assessment o Most recent annual medical assessment <u>Trends analysis of benzodiazepine use at the Facility</u> The Facility conducts a semiannual trends analysis of benzodiazepines usage, which is reviewed every six months at the psychotropic medication oversight committee (PMOC) meeting. The 5/9/2013 PMOC meeting minutes reflected a review of the Facility's usage	Substantial Compliance

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		of benzodiazepines, and reported that a total of 61 individuals were prescribed a benzodiazepine, of which 28 were for a neurology indication, and 33 were for psychiatric indication. The PMOC minutes, however, did not document the committee members' review and comments, specific to the Facility's usage of benzodiazepines. <u>Assessment of Benzodiazepine usage</u> Based on review of the clinical documents, per the document request, the Monitoring Team made the following determination, for Individuals #367, #1, #270, #582, #255, #539, #554, #43, #159, and #35: • In ten out of ten cases (100%), the QDRR documented the use and indication for the use of the benzodiazepine. • In one out of ten cases (10%), the QDRR documented risks associated with the use of the benzodiazepine; however, review of associated IRRFs indicated that nine out of ten examples (90%) comment on risks associated with benzodiazepine. The statement of risks could be more comprehensive. The Monitoring Team suggests it is important to comment on specific risks associated with the use of benzodiazepines. Paradoxical agitation, cognitive decline, and fall risk are all important risks that should be clearly understood by the IDT, delineated on the QDRR, and considered in developing the IRRF. • In eight out of ten examples (80%), the QDRR documented efficacy or lack of efficacy for the benzodiazepine. • In ten out of ten cases (100%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. <u>Summary</u> The Facility conducts a semiannual systems review for the usage of benzodiazepines. The Monitoring Team suggests that the PMOC committee ensures documentation on PMOC minutes of its agreement or disagreement with the reported trends analysis for benzodiazepine usage, completed by the pharmacist. Individual QDRRs included specific review and documentation of usage of benzodiazepines, and associated IRFFs documented benzodiazepine usage, however, specific adverse effects of benzodiazepines, such as cognitive decline, paradoxical behavior exacerbation, and fall risks were not documented on the IRRF, or the QDRR, and the pharmacists determination of appropriate dosage was not routinely documented. Because the Facility documented the indication and clinical rationale, and included benzodiazepines on the IRFF, the Monitoring Team will continue substantial compliance; however, the Facility must ensure that relevant risks associated with benzodiazepine use are well documented on the IRFF and QDRR, and the pharmacist must indicate if the medication is efficacious, and that the specific dose in justifiable.	

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		<u>Assessment of Metabolic Syndrome Monitoring:</u> The Monitoring Team selected the first five and last five individuals on a list of all individuals that are on a neuroleptic and had a diagnosis of diabetes, or hypertension, and reviewed the following documents to assess the Facility's monitoring of metabolic syndrome. Nine of the ten requested examples were provided (Individuals #305, #133, #243, #403, #488, #152, #24, #10, and #300) • Most recent QDRR • Most recent IRRF • Current medication list • Most recent six months laboratory data • Most recent annual medical assessment • Most recent psychiatric assessment • Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome Nine out of nine QDRRs (100%) indicated specific review for metabolic syndrome. Nine out of nine QDRRs (100%) assessed clinically appropriate risk factors to assess for metabolic syndrome (100%). The associated IRRF documented a specific risk assessment for metabolic syndrome in eight out of nine examples (89%). The Pharmacist discussed the risk benefit for either continuing or discontinuing the medication associated with metabolic risk in zero out of nine examples (0%). Summary QDRRs indicated a specific and comprehensive review for metabolic syndrome. Beginning with this review period, the Monitoring Team began assessing if the pharmacist specifically addressed the risk and benefits associated with prescribed medications and metabolic syndrome, and if they offered potential alternative therapies, when clinically appropriate; hence, the Monitoring Team strongly recommends that the pharmacist begin addressing specific risks and benefits associated with pharmacological treatments that are associated with metabolic syndrome, and when clinically appropriate, provide recommendations for alternative treatment. <u>Review of Anticholinergic Usage</u> To assess the Pharmacists' participation in the monitoring of anticholinergic drug usage at the Facility, the Monitoring Team requested the following documents:	

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		• Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties • Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties • Alpha list of individuals who are prescribed anticholinergic drugs • For the first ten individuals on the list of individuals prescribed anticholinergic drugs (Individuals #96, #413, #189, #332, #133, #205, #89, #331, #59, and #492) o Most recent two QDRRs o Current medical list o Most recent medical, and psychiatric annual reviews o Most recent MOSES and DISCUS assessments <u>Systems review of anticholinergic drug utilization:</u> The Facility provided data, and summary of data analysis, indicating the usage of anticholinergic medications at the Facility. Data charts tracking the number of individuals prescribed anticholinergic medications indicated continued reduction in the usage of anticholinergic medications at the Facility. For example, between January 2010, and July 2013, the total number of individuals receiving anticholinergic medications was decreased from 59 individuals to 28 individuals, and from January 2013 to July 2013, the total number of individuals prescribed anticholinergic medications decreased from 52 to 48 individuals. The Facility documented a summary of the data analysis, and presented it at the 8/2/2013 Psychotropic Medication Oversight Committee (PMOC) Meeting. The PMOC minutes, however, did not document the committee members review and comments, specific to the Facility's usage of anticholinergics. The following is a summary of the pharmacy's clinical review of anticholinergic medications during the QDRR process for individuals # • In nine out of ten cases (90%) the QDRR documented the indication for the use of all anticholinergics prescribed. The QDRR for Individual #492 did not comment on anticholinergic use, despite being provided as an example of an Individual prescribed an anticholinergic medication. • In nine out of ten cases (90%), the QDRR documented risks associated with the use of anticholinergics. The QDRR for Individual #492 did not comment on anticholinergic use, despite being provided as an example of an Individual prescribed an anticholinergic medication. • In three out of ten cases (30%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics. Summary:	

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		The Facility demonstrated a review of anticholinergic medication usage in 90% of the examples reviewed by documenting specific usage and indication, as well as risk associated with anticholinergic use. Beginning with this review period, the Monitoring Team began assessing if the pharmacist specifically documented the appropriateness of the current dose of anticholinergic medication, if the use was clinically appropriate or not; if the anticholinergic medication was efficacious or lacked efficacy; and when clinically indicated, alternative pharmacotherapy. The Monitoring Team strongly recommends that the Facility ensure documentation on these monitoring parameters for future reviews. <u>Review of polypharmacy usage</u>: To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents: • POMC meeting minutes for 4/2013 through 10/2013 • List of all individuals on polypharmacy • For the first, and than every second individual on the list of polypharmacy, for a total of ten individuals (Individuals #367, #1, #471, #248, #582, #167, #439, #61, #19, and #75): o Most recent two QDRRs o Most recent psychiatric assessment o Current medication list o Most recent ISP, or related document the use of polypharmacy <u>Systems review of psychotropic polypharmacy</u> The Facility provided PMOC meeting minutes, and associated data graphs, and summary of the data for psychotropic polypharmacy. The Facility provided comprehensive data, and data analysis, of psychotropic polypharmacy usage. As of 9/18/2013, a total of 134 individuals were prescribed psychotropic medications, and 46 individuals (34%) were prescribed two or more psychotropic medications. Specific to antipsychotic medications, the Facility reports that only eight individuals were prescribed two or more antipsychotic medications. Committee meeting minutes demonstrated a comprehensive review of psychotropic polypharmacy. The following is a summary of the documents reviewed for polypharmacy: • In ten out of ten examples (100%) the QDRR documented the indication for the use of each polypharmacy agent. • In zero of ten examples (0%), the QDRR documented serious risks for the use the polypharmacy combination. Despite indication that the pharmacist reviewed the MOSES and DISCUS assessment results, The QDRR did not list specific potential side effects, and other potential consequences, such as drug-drug	

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		interactions, that should be closely monitored. Within the context of a developmental center, all known, and possible risks associated with prescribed medications must be made well aware to other IDT members, by ensuring that relevant risks for prescribed medications are documented on the QDRR, and on the IRRF. The QDRR should provide other IDT members an understanding of the risks associated with the prescribed polypharmacy, and that was not clearly delineated. The Monitoring Team had not reviewed this issue at the last compliance visit. Therefore, although this provision will remain in substantial compliance, the Facility must address this issue quickly in order to be found in compliance at the next compliance visit. • In ten out of ten examples (100%), the current IRRF assessment documented risks associated with polypharmacy. • In ten out of ten cases (100%), the QDRR documented clinically justifiable recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. The QDRR must document recommendations for each medication associated with polypharmacy. • In three out of ten cases (30%), the pharmacist documented the efficacy, or lack of efficacy for the use of polypharmacy. The QDRR should document the efficacy, or lack of efficacy for the polypharmacy. This also was not discussed in the last report and will be reviewed for compliance at the next visit. • In ten out of ten examples (100%), the current IRRF assessment documented risks associated with polypharmacy. Summary The Facility demonstrated a review of polypharmacy usage in 90% of the examples reviewed by documenting specific usage and indication. Beginning with this review period, the Monitoring Team began assessing if the pharmacist specifically documented if the polypharmacy was clinically justifiable or not; if the polypharmacy was efficacious or lacked efficacy; and when clinically indicated, offered alternative pharmacotherapy. The Monitoring Team strongly recommends that the Facility ensure documentation on these monitoring parameters for future reviews. <u>Review of STAT Chemical Restraint usage</u>: As reported in Provision C1, there was only one use of chemical restraint reported from April 2013 through September 2013. Furthermore, upon review of the 49 QDRRs for this report (Individuals #367, #1, #471, #248, #582, #167, #439, #61, #19, #75, #96, #413, #189, #332, #133, #205, #89, #331, #59, #492, #305, #243, #403, #488, #152, #24, #10, #300, #367, #270, #582, #255, #539, #554, #43, #159, #35, #403, #223, #483, #41, #519, #570, #140, #45, #404, #27, #189, #81)., there were no examples of stat chemical restraint usage. Therefore, the Monitoring Team did not review the	

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		pharmacy's systems for stat chemical restraint usage. At subsequent reviews the Monitoring Team will assess the pharmacy's systems review for stat chemical restraint usage, and to ensure that the reviewing pharmacist documents: specific circumstances of the behavior exacerbation, or other need for the stat chemical restraint, and if the medication was justified; effectiveness of the chemical restraint; if side effects or other adverse effects occurred during the stat chemical restraint; evaluation to assess efficacy of the maintenance medication, and recommendation to adjust or change the maintenance medication if necessary. The pharmacy review should be completed by the following business day and specific recommendations should be documented, when necessary. In addition, the pharmacist should review, and concur or disagree with, the psychiatrist's review of the stat chemical restraint, that documents the following information: Description of the behavioral exacerbation, and justification for the use of the stat chemical restraint; comment on the appropriateness of the maintenance medications; review of the appropriateness of the PBSP, and relevant environmental factors associated with the behavioral exacerbation; assessment of possible side effects from the stat chemical restraint; efficacy of the stat medication; and comment about the risks of drug-drug interaction; and specific recommendations, when necessary. The pharmacist's and psychiatrist's assessment and recommendations for the stat chemical restraint usage should be reviewed by each other, and by other members of the IDT. <u>Conclusion</u>: The Facility continued to ensure that metabolic syndrome, polypharmacy, anticholinergic, and benzodiazepine usage is addressed when completing QDRRs and ensured that regularly scheduled systems review of benzodiazepine, anticholinergic, and polypharmacy usage is conducted through relevant committee structure. For these reasons the Facility remains in substantial compliance. Beginning with this review, the Monitoring Team began assessing to ensure that appropriate dosage, clinical rationale, alternative pharmacotherapy, efficacy of pharmacotherapy, and pharmacotherapy risks be documented on the QDRR, and strongly recommends the pharmacy department ensure that the pharmacist documents review of each of these issues on subsequent QDRRs.	
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	To assess the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' response to the recommendations, the Monitoring Team assessed the QDRRs reviewed for Provisions N.2 and N.3 of this report, and the following information for the first two single patient drug intervention reports (SPDI) that were completed each month from April 2013, through October 2013 (Individuals #133, #120, #159, #493, #19, #568, #508, #93, #270, #53, #570, and #206): • SPDI (single patient drug intervention) report	Substantial Compliance

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	followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	• Copy of associated medication order • Documentation of pharmacist's review of the order • Clinical evidence for the medical provider following up on the recommendation, or alternative rationale Review of the requested documents indicated the following: • Review of 49 QDRRs from Provision N.2, and N.3 of this reported indicated that the medical provider documented review of the QDRR and pharmacists recommendations in 48, out of 49 examples (98%). In all examples, the medical provider signed the QDRR within 14 calendar days from the completion date of the QDRR. • There were no examples of the medical provider not agreeing with the pharmacist's recommendations. • Twelve out of 12 SPDI reports and supporting documentation (100%) indicated that the medical provider either accepted the pharmacist's recommendations or provided clinical rationale for not following the pharmacist's recommendations. • There was supporting documentation that appropriate clinical action was taken for nine out of 12 SPDIs (75%). There was no evidence to support that the pharmacist's recommendations were followed for Individuals #120, #493, and #206. • A SPDI physician notification form was provided for six out of 12 examples (50%); for the six SPDIs provided to the medical provider, six out of six (100%) were completed by the medical provider. • For the six SPDIs that did not include an SPDI physician notification form, there was indication that the medical provider was notified by telephone, and provided verbal confirmation for the recommendation in six out of six examples (100%). Conclusion: The Facility continues to ensure that medical provider's review, and appropriately follow-up on pharmacy recommendations. The Facility should improve the documentation to support that appropriate clinical action was taken for each SPDI. The Facility remains in substantial compliance with Provision N.4.	
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	To assess the Facility's ability to ensure clinically appropriate drug monitoring of tardive dyskinesia, the Monitoring Team requested all MOSES and DISCUS assessments completed for the first ten individuals, beginning in 4/1/2013, following either a dose increase of a prescribed neuroleptic, or if a new neuroleptic was initiated. The reader is also referred to Provision J.12 of this report for additional comments regarding drug side effect monitoring.	Substantial Compliance

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	dyskinesia.	The following is a summary of the Monitoring Team's review of the MOSES and DISCUS assessments provided for review (Individuals #579, #144X2, #159, #250, #152, #42X2; #243, and #417): • More frequent monitoring for tardive dyskinesia was noted in eight out of ten examples (80%): o Individual #152 was initiated on a neuroleptic on 6/6/2013, and the only DISCUS assessment provided was from 9/19/2013. o Individual #243 was initiated on Zyprexa on 7/9/2013, and the only MOSES and DISCUS provided for review was from 8/29/2013, six weeks following initiation of the neuroleptic. • Of the 34 combined MOSES and DISCUS assessments reviewed, one out of 34 (2%) were completed, and signed by the medical provider. The Monitoring Team recognizes that the Facility had recently switched to an electronic format for reporting on MOSES and DISCUS assessments, and that remediation steps are now in place to ensure that MOSES and DISCUS will be completed and signed by the medical provider. Conclusion: The Facility demonstrated enhanced monitoring of tardive dyskinesia in 80% of the examples assessed and substantial compliance is continued. The Monitoring Team recognizes that the Facility had recently implemented an electronic version of the MOSES and DISCUS assessments, and these assessments did not include documentation of the medical provider's completion of the assessments. For future reviews, substantial compliance will require that all MOSES and DISCUS assessments be fully completed by the medical provider; and evidence must indicate that all individuals who have either been started on a new neuroleptic, or prescribed a dose increase of a neuroleptic, be provided enhanced monitoring for tardive dyskinesia.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	To assess the Facility's ADR (adverse drug reaction) process, the Monitoring Team requested all associated clinical documentation for the first, and then every second ADR, for a total of ten ADRs, that occurred beginning 4/1/2013; updated policies and procedures for ADRs; all data, trends analysis, summary review, and committee meeting minutes related to a system review of ADRs at the Facility; and staff training materials, specific to the ADR process. The pharmacy department provided an ADR tracking and trending spreadsheet that indicated that five ADRs were reported during the reporting period (Individuals #444, #159, #148, #68, and #422). Two of the five ADRs reached a severity that required reporting to the FDA.	Substantial Compliance

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		The Facility reports ADRs at the quarterly pharmacy and therapeutics committee meeting (P&TC). Review of the P&TC meeting minutes for 7/25/2013 and 10/10/2013 indicated that all ADRs that were reported during quarter were documented on the P&TC meeting minutes, and reflected a comprehensive review by the P&TC members, that included a review of each ADR, and summary of action steps that were taken specific each ADR. For example, Individual #422 was prescribed Lioresal at the FDA approved dosage, and the Individual developed hypoxia, lethargy, and urinary retention. The medication was discontinued, the individual improved, and the Facility reported the ADR to the FDA, through the FDA's MedWatch program. The Facility maintained a database of all ADRs that includes the individual's name, living area, ADR associated medication, date ADR was identified, type of clinical reaction, and if the ADR was or was not reported to the FDA. The Facility provided training rosters that indicated all direct support staff, nurses, medical providers, PT/OT, and pharmacists had been trained on identifying and reporting ADRs. The Facility also included a copy of the Pharmacy Services and Safe Medication Practices; Adverse Drug Reaction policy, revised 10/10/2013, indicating that all new employees will be provided training on identifying and reporting of ADRs during the orientation process. The following is a summary of the examples reviewed by the Monitoring Team: • An ADR reporting form was completed for each ADR reported during the review period, in six out of six examples (100%). • The ADR reporting form was fully completed in six out of six examples (100%). • The medical provider signed the ADR reporting form in zero out of six examples (0%). The ADR reporting form did not have a section for the medical provider to complete or to sign indicating review of the ADR; however, in six out of six examples, the ADR reporting form indicated that the medical provider was informed of the ADR. • The pharmacist provided comments regarding the ADR in six out of six examples (100%). Section I of the ADR reporting form has a section listing action steps taken to prevent future ADRs from occurring. • Clinically appropriate follow-up and, or treatments for the ADR was noted in six out of six examples (100%). • There was a severity level documented on the ADR reporting form in zero out of six examples (0%). • For the six ADRs reviewed, six out of six (100%) were reported by pharmacists, as evidence by the pharmacist signing section I of the ADR reporting form.	

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		• The ADR was reported by medical providers and nurses at the time of the initial clinical manifestation in two out of six examples (33%). The pharmacy identified the remaining four when doing QDRRs, which is a positive finding. Conclusion The Facility maintains an ADR reporting process and reported a total of six ADRs during this review period. There was evidence to indicate that all relevant staff had been trained on reporting ADRs. The Monitoring Team was concerned over the lack of reporting of ADRs from staff, other than the clinical pharmacist. Also, it was apparent that only two out of six examples (33%) were reported at the time of the clinical manifestation of the ADR, and in most cases, the ADR reporting form was completed retrospectively by the clinical pharmacist. The Monitoring Team will continue compliance at this time; however, at future reviews, the Facility must ensure more timely reporting of ADRs by staff. The Monitoring Team also suggests that the ADR reporting form be revised to more clearly document clinical follow-up to the ADR by the medical provider, and to identify specific clinical recommendations by the pharmacist.	
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.	To assess the Facility's development and provision of drug utilization evaluations (DUEs) the Monitoring Team requested the following information: • Complete DUE schedule for 2012 and 2013, to include all DUEs provided and pending • Copies of all DUEs provided during the reporting period <u>DUE Schedule:</u> The Monitoring Team reviewed the 2013 DUE schedule and noted that the Facility completed four DUE's during the reporting period. <u>Review of completed DUEs:</u> The Facility provided copies of the following DUEs, that were completed during the reporting period: • Lithium • Clozapine • Acetaminophen • Fluoroquinolones The Monitoring Team noted that the DUEs provided an excellent review of drug utilization, and meaningful clinical information was well delineated in each report. <u>FDA advisories:</u> The FDA issued many advisories during the six-month reporting period. The FDA	Substantial Compliance

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		advisories relevant to the medical providers at the Facility included warning for the following drugs: • Acetaminophen – severe skin reactions • Fluoroquinolones – peripheral neuropathy • Ketoconazole – fatal liver injury • Olanzapine Pamoate – unexpected deaths The Facility reported that it did not address the FDA's alert for ketoconzole, and olanzapine pamoate, because the products were not used at the Facility at the time the alert was issued. The Facility did provide DUEs for acetaminophen, and fluoroquinolones. <u>Conclusion:</u> The Facility maintained a process for providing clinically relevant DUEs, and provided four DUEs during the reporting Period. The DUEs provided demonstrating clinically relevant information, and provided medical providers and pharmacists with information to enhance clinical practice. The Facility provided DUEs for two FDA advisories; because the Facility did not administer olanzapine pamoate or oral ketoconazole, at the time of the FDA advisory, the Facility did not provide a formal DUE or other form of in-service to medical providers for these two drugs. Both oral ketoconazole, and olanzapine pamoate are commonly used medications in the community, and although the Facility may or may not have individuals currently one such medications, it is important that the medical providers, and pharmacists are provided information on these important advisories, to keep providers current on such medications, as that information may influence their prescribing practice in the future. Substantial compliance will be continued at this time; however, to maintain compliance, the Monitoring Team strongly recommends that the Facility ensure that medical providers and pharmacists are provided a DUE or alternative in-service training for FDA advisories for specific classes of drug that are commonly used in general medicine and psychiatry.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The Monitoring Team assessed the Facility's medication variance process by reviewing the following documents: • BSSLC Policy N.12 Pharmacy Services and Safe Medication Practices, Medication Variances 6/5/13 • Medication variance committee meeting minutes, for 5/2013 through 9/2013 • All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances • List of all medication variances that occurred during the reporting period • For the first, and than every second individual listed on the medication variance list (for a total of ten examples):	Substantial Compliance

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		o Copy of completed medication variance report form o All physician IPNs associated with the medication variance o All nursing IPNs associated with the medication variance o All pharmacy documentation, and communication related to the mediation variance o All IDT minutes specific to the medication variance o Documentation that the guardian was notified of medication variance of category C or worse The Monitoring Team attended the Medication Variance Committee Meeting on October 9. 2013. <u>Policy</u> BSSLC Policy N.12 Pharmacy Services and Safe Medication Practices, Medication Variances was taught to all new Facility and agency nurses during orientation. <u>Completion of Medication Variance Report Forms:</u> The Facility provided nine of the ten requested completed medication variance report forms. Review of the medication variance report forms indicated the following: • The Medication Variance forms were fully completed, and indicated the type of variance, severity index, physician notification, and review by the department supervisor, in nine out of nine examples (100%). • The department supervisor documented appropriate corrective action in nine out of nine examples (100%). • The Facility reporting form did not include a section for pharmacy review, and did not provide additional supporting evidence of a pharmacist's review, and recommendations. The Facility should strongly consider adding such a section to provide documentation of review and of any recommendations. • Medication variances were incorporated into the medication variance database, and after analysis was presented to the medication variance committee for review in nine out of nine (100%) examples. <u>Medication Variance Monitoring and Analysis</u> The Facility continued to maintain an excellent Medication Variance Database to record, track, analyze, trend, and report data. The Monitoring Team refers the reader to Provision M.6, of this report, for a comprehensive review of the Facility's data analysis of medication variances that occurred during the reporting period. <u>Completion of Medication Variance Reports</u> The Monitoring Team reviewed ten of the most recently completed Medication Variance	

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		Reports for Individuals #34 #490, #205, #570 (two reports), #536, #243, #248, #75, and #400. Findings include: • The Medication Variance forms were fully completed, and indicated the type of variance, severity index, physician notification, and review by the department supervisor, in ten out of ten (100%) examples. • The department supervisor documented appropriate corrective action in ten out of ten (100%) examples. • Nursing Administration reviewed the Medication Variance Reports before they were entered into the Medication Variance Database for any corrections and further corrective action when indicated. • Medication variances were incorporated into the medication variance database and after analysis and were presented to the Medication Variance Committee for review in ten out of ten (100%) examples. <u>Medication Variance Committee</u> Of the monthly Medication Variance Committee Meetings scheduled, six of six (100%) occurred as scheduled. The meetings were well attended by the core membership. The Committee continued to be chaired jointly by the Pharmacist Director and Nursing Operations Officer. The committee continued to analyze and trend monthly and quarterly Medication Variance Data Reports by: department, severity levels, types of medication variances, classification of medications, and contributing factors for Units/Cottages, homes, shifts, and facility-wide. In addition, monthly Medication Observation, Medication Administration Record Audits, and Medication Room Audits were reported at the meetings. Review of the medication variance committee meeting minutes for 5/2013 through 9/2013, indicated data analysis, summary of the medication variances, and documentation of corrective actions when necessary for nursing and pharmacy related medication variances. The pharmacy director attended all Medication Variance Committee meetings, and reported on pharmacy related variances, and indicated corrective action steps for each variance reported. The medical director attended all Medication Variance Committee meetings, and documented specific medication variances associated with medical providers; however, the medical provider did not indicate corrective action steps for variances reported on the 7/2013, 8/2013, and 9/2013 medication variance committee meeting minutes. The Monitoring Team also noted that the Medication Variance Committee meeting minutes did not include a section documenting newly developed action plans, nor was there consistent documentation on follow-up to previously identified action plans. The findings from the Medication Variance Committee Meeting continued to be reviewed	

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		and discussed at the quarterly Pharmacy and Therapeutic Committee Meetings. Conclusion Because the Facility maintained a medication variance process that promptly addressed all reported medication variances, tracked and trended prescribing, documenting, dispensing, administering, storage of medication variances; and because nursing, pharmacy and medical leadership participate in the medication variance process, the Monitoring Team continued substantial compliance at this time. The Monitoring Team strongly recommends that the Facility develop a specific section on the medication variances committee minutes, for all newly developed action plans, and a section for follow-up to action plans. In addition, the Facility should also ensure a process that documents the pharmacists review of each medication variances, and when clinically appropriate, provides clinical recommendations.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment, dated 9/23/13 2. BSSLC Action Plan 9/19/13 3. Section O Presentation Book 4. BSSLC Policy P.1 Habilitation Therapy Services 8/5/13 5. BSSLC Policy P.2 PNM Plans 7/13/12 6. BSSLC Policy O.1 Physical and Nutritional Management Team 11/27/12 7. PNMT Discharge Flow Chart (9/27/13) Record reviews: 8. Sample O.1: Individuals #15, #38, #41, #59, #89, #138, #153, #187, #243, #305, #392, #493, #539, and #597 9. Sample O.2: Individuals $41, #88, #89, #112, and #293, 10. Sample O.3: Individuals #37, #87, #186, #253, #428, and #570 11. Lists of individuals: a. Who cannot feed himself or herself and notation of any changes since the last review; b. Who require positioning assistance associated with swallowing activities and notation of any changes since the last review; c. Who have difficulty swallowing and notation of any changes since the last review; d. At high and/or medium risk for aspiration pneumonia and choking; e. With choking incidents since the last compliance review f. Who had a feeding tube inserted since the last compliance review g. Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis h. Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) i. With falls in the last 6 months (date, location , type of injury) j. With chronic respiratory infections k. With chronic dehydration l. With fecal impaction m. With pressure ulcers in the last 6 months (date, location and resolution) n. With fractures in the last year (date, location of fracture, status) o. Who were non-ambulatory or require assisted ambulation p. With wheelchairs for primary mobility q. With wheelchairs for transport r. Who use Assistive Devices for ambulation (type of device) s. With orthotic/braces

	12. Caseloads of PNMT dedicated and non-dedicated members 13. List of medical consultants to the PNMT (e.g., medical doctor, nurse practitioner, or physician's assistant) and PNMT meeting minutes and attendance sheets for presence and participation of a medical doctor, nurse practitioner or physician assistant, and other IDT members as needed or defined in Facility policy 14. PNMT members and PNMT back up curriculum vitas 15. QA reports/matrix since the last compliance review 16. List of referrals to the PNMT since the last compliance visit 17. PNMT RN post hospitalization assessments completed since the last compliance visit 18. PNMT assessment template 19. PNMT Action Plan template 20. IRRF template 21. IHCP template 22. List of new employees since last compliance visit and their PNM related performance check offs 23. List of staff assigned to train other staff on the PNM core competencies (i.e., foundational skills) and dates of training, including back-up training records (i.e., sign-in sheets and competency check-offs) 24. Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training 25. PNM Monitoring Tool template 26. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 27. For Individuals in Sample: a. All ISPs in the last 12 months b. All ISPAs in the last 6 months c. All IRRFs in the last 12 months d. All IRRF Action Plans in the last 12 months e. IHCP/Action Plan f. QIDP Monthly Reviews for the last 6 months g. PBSPs h. Braden Scale forms i. Annual weight graph j. Nutrition tab, including assessments and reviews k. Head of Bed Elevation (HOBE) assessments l. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted m. OT/PT assessments in the last 12 months n. SLP assessments, including Communication/AAC in the last 12 months o. Trigger sheets completed in the last 6 months, including the current month p. PNMPs in the last 12 months, including pictures q. Dining Plans in the last 6 months, including pictures r. Completed PNM-related monitoring sheets in the last three months s. Evidence of effectiveness monitoring completed within the last six months

	t. Aspiration Pneumonia Enteral Nutrition (APEN) in the last 6 months u. Plan for individuals who are returning to oral eating and supporting documentation for implementation of plan (i.e., staff training documentation, staff roles and responsibilities, specific triggers when the plan should be stopped, milestones for progress with the plan, documentation requirements to track progress, frequency of subsequent assessments and staff responsible, and monthly progress notes) v. Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) w. Individual notebooks (PNM section) **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA), 3. Christina Koehn SLP 4. Direct Care Professionals on (2) Childress, (4) Driscoll, and (2) Bowie. **Meetings Attended/Observations:** 1. PNMT meeting 10/8/13 2. Mealtimes and transitions (Bowie, Fannin, Childress, and Driscoll) 3. Daily activities on Driscoll, Childress, and Fannin
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 9/23/13 and Action Plan dated 9/19/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section O, in conducting its self-assessment, the Facility: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section O. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example, The Self Assessment for Provision O.1 only included evidence of PNMT composition and attendance and did not include information regarding the need for a comprehensive PNMT policy or the need for specialized training in the form of continuing education. o The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools, such as Facility therapists (i.e., OTs, PTs, and SLPs); therefore there was no evidence staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the

	Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with four of the provisions of Section O (Provisions O.1, O.2, O.3 and O.8). This was inconsistent with the Monitoring Team's findings. The Monitoring Team found BSSLC to be in compliance with Provisions O.1 and O.8 but not be in compliance with Provisions O.2, O.3, O.4, O.5, O.6, and O.7. o Provision O.2 was determined to be not in compliance. The risk process continued to improve in its ability to identify those individuals who are at increased risk. PNMT assessments/reviews lacked evidence that all potential areas impacted by the change in PNM status were at a minimum reviewed/discussed as part of the meeting. o Provision O.3 was found not to be in compliance due to PNMPs not being comprehensively reviewed by the individual's IDT in the annual ISP meeting. Additionally, while BSSLC addressed concerns with the positioning details in Sample O.1, it was noted to be a pervasive issue and one that BSSLC needed to address prior to obtaining substantial compliance. The Action plans developed were felt to move BSSLC in the right direction towards compliance; however, BSSLC should continue to review the findings of the Monitor's report and revise the Action Plans as indicated to address all identified concerns. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan.
	Summary of Monitor's Assessment: Overall, there has been noted improvement with all provisions in Section O. BSSLC continued to show progress across areas that required direct clinical skill such as PNMT meetings or assessments as well as systems components such as implementation of PNM related strategies. **Provision O.1:** This provision was determined to be in substantial compliance. BSSLC had a Physical and Nutritional Management Team that included all the relevant professionals and great strides had been made regarding the collection of data and the reviewing of this data to better identify system issues or respond to recurrent issues on a regular basis. **Provision O.2:** This provision was determined to be not in compliance. The risk process continued to improve in its ability to identify those individuals who are at increased risk. PNMT assessments/reviews lacked evidence that all potential areas impacted by the change in PNM status were at a minimum reviewed/discussed as part of the meeting. **Provision O.3:** This provision was determined to be not in compliance. PNMPs were not being comprehensively reviewed by the individual's IDT during the annual ISP meeting and there was lack of consistent participation by Occupational Therapy, Physical Therapy and Speech Pathology at the ISP meetings. Additionally, while BSSLC addressed concerns with the positioning details in Sample O.1, it was noted to be a pervasive issue and one that BSSLC needed to address prior to obtaining substantial

	compliance. **Provision O.4:** This provision was determined to be not in compliance. PNMPs were readily available to staff. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. Nevertheless, staff were observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were observed poorly positioned in their wheelchairs and in recliners. **Provision O.5:** This provision was determined to be not in compliance. A formal process did not exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. **Provision O.6:** This provision was determined to be not in compliance. BSSLC had ample frequency of monitoring and there was evidence that monitoring occurred across many of the settings that were likely to provoke swallowing difficulties, but there was no evidence that staff or the individual was monitored across all three shifts. Additionally, there was not a clear process that outlined how data acquired through the monitoring would be analyzed. **Provision O.7:** This provision was determined to be not in compliance. Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem. There was limited evidence of monthly review by the QIDP to ensure the PNMP remained effective in mitigating risks associated with PNM. **Provision O.8:** This provision was determined to be in substantial compliance. Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake.

#	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	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of 14 individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	PNM concerns (e.g., admitted to the facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of seven individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of six individuals at BSSLC who received enteral nutrition. Some of these individuals might have been included in one of the other samples. Sample O.4 consisted of 43 individuals observed on Bowie, Childress, Fannin, and Driscoll during positioning and mealtimes This provision was determined to be in substantial compliance. BSSLC had a policy that addressed the needed components to ensure implementation of the PNMT process. Components missing from the policy included requirements for continuing education for PNMT members, collaboration with the Dental Department to address the risk of aspiration during and after dental appointments including after the use of general anesthesia, the requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs, and requirements for continuing education for PNMT members. Although not fully included in policy, missing components were observed in practice during the course of the compliance visit. It is recommended that in order to ensure sustained substantial compliance with Provision O.1, BSSLC should move forward with including the missing components into formalized policies and/or procedures. **PNM Policy and Role of the PNMT:** While the Facility did not have evidence of a PNM Policy that addressed all the listed components, the areas that were not addressed in policy were in practice and occurring on a consistent basis. The PNM policy did include: • Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT;	

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		▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ A comprehensive PNM monitoring process designed to address all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and o Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system should include: o Requirements that the QA matrix include key indicators related to PNM	

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		outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. Policy indicators missing included: ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. Although not in policy, all coursework completed by members of the PNMT were relevant to the population served as well as PNM issues. ▪ Requirements for continuing education for PNMT members; (Although this was not included as part of the policy, through review of CEUs completed, PNMT members were noted to have received relevant training. ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia. Although this was not noted in policy, per the HT director, the PNMPs were beginning to be reviewed on an annual basis by the Dental Department. Discussion with the Habilitation Therapy (HT) Director regarding the treatment of high risk dental and aspiration individuals revealed: o All individuals were kept in the most upright position possible during oral procedures. o Water was not used with High Risk individuals. o Suction was utilized during and post procedures.	

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		In order to retain substantial compliance, the Facility must integrate the above components into the state and/or local policy. An area of improvement was the PNMT's involvement in reviewing and analyzing facility trends related to their scope of practice. This included but was not limited to pneumonia, weight loss, and skin breakdown. Evidence of this analysis was well documented in the PNMT minutes and included corrective action plans to address any noticeable negative trends. An example was the PNMT's review of enteral nutrition and the impact of bolus/continuous/gravity type feedings on the rate of pneumonia. In addition to the review of the enteral nutrition, the PNMT had a monthly schedule that included review of facility PNMPs, weight issues, skin integrity, and pneumonia. **Core PNMT Membership:** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did have the appropriate disciplines as defined in the Settlement Agreement. BSSLC had identified the Registered Nurse (RN), Physical Therapist (PT), Speech Language Pathologist (SLP), Occupational Therapist (OT), Registered Dietitian (RD) and Physician (MD) as standing core members. Additionally, a Senior Direct Support Professional (DSP-IV) was also present at many of the meetings. **Consultation with Medical Providers and IDT Members** For seven of seven individuals in Sample 0.2 (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. For seven of seven individuals in Sample 0.2 (100%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Six of six core PNMT members (100%) were licensed to practice in the state of Texas. Six of six core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. **Continuing Education** Five of six core PNMT staff (83%) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferrable to the	

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		population served within the past 12 months. Examples of continuing education included but were not limited to: ▪ PT attended: Effective Sensory Diets ▪ SLP attended: Evaluation and Treatment of Chronic Cough ▪ OT attended: Medication Administration for Nurses ▪ RD attended: Overview of the Nutrition Care Process ▪ RN attended: Common Medication Interactions and Side Effects. While the RD did not attend 12 hours in the last 12 months, there was evidence that six trainings that did not provide CEUs were attended. **PNMT Meetings** From 4/16/13 to 8/28/13, of the 20 weeks, the team met on 20 of 20 weeks (100%). All core members of the PNMT were present for at least 80% of meetings. Attendance by core PNMT members for 20 meetings conducted during the time frame from 4/16/13 to 8/28/13 was: ▪ Chairperson/Coordinator/PNMT PT: 80% attendance by core member ▪ RN: 95% attendance by core member ▪ OT: 95% attendance by core member ▪ SLP: 95% attendance by core member ▪ RD: 90% attendance by core member Other members identified by BSSLC as being core PNMT members had the following attendance figures: ▪ MD: 90% attendance Twenty of 20 PNMT meeting minutes (100%) include documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. The Facility PNMT did have a sustainable system fully implemented for resolution of systemic issues/concerns. The system included but was no limited to: ▪ How monitoring data from the QA Department as well as Habilitation Therapies and the PNMT was collected, trended, and analyzed; ▪ How Habilitation Therapies and the PNMT identified and presented systemic issues requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting, and PNMT meeting).	

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O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	**Identification of PNM risk** Two hundred sixty five of 265 individuals (100%) who cannot feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. The Facility had a sustainable system to maintain and update lists of 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"). BSSLC continued to show an improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM. Seventeen of 17 individuals in Samples O.1 and O.2 (100%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). **Physical and Nutritional Management Team Referral Process** Seven of seven individuals from Sample O.1 were appropriately referred to the PNMT based on the criteria included in the Facility policy. In seven of seven individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral or review to/by the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. BSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Based on these discussions, if PNMT involvement was felt to be needed then the IDT was contacted so that a joint meeting would occur to discuss the findings of the assessment, concerns of the PNMT, and how the PNMT could support the IDT by providing a focused or full assessment or by merely discussing the issue and providing guidance to the individual's IDT. As a result, initiation and receipt of the referral occurred simultaneously and well within five working days. Another method in which the PNMT was made aware of changes in status was through participation by the PNMT lead and PNMT RN in the morning medical meeting.	Noncompliance

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		Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. A new component of the PNMT meeting that was noted through review of PNMT minutes was the PNMTs involvement in the review of pneumonia and skin breakdown trends. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. This was a positive achievement of the PNMT. Two of two individuals from Sample O.1 who received a feeding tube since the last review (100%) had been referred to or discussed by the PNMT prior to the placement of the tube. **PNMT Assessment** Five of five PNMT assessments/reviews for individuals in Sample O.2 (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). BSSLC's RN provides assessment upon return from the hospital in an effort to identify any concerns noted with PNM. Results of the assessment were discussed at the PNMT at the weekly meeting or sooner as indicated. Referrals that were submitted by the IDT outside of a return from hospitalization were discussed at the following PNMT weekly meeting with PNMT attending the IDT as indicated. Five of five PNMT assessments in Sample O.2 (100%) were completed within no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances Based on review of individuals' records who were referred to the PNMT (Sample O.2), the comprehensiveness of the PNMT assessment components were as follows: • Five of five (100%) contained date of referral by the IDT. This information was contained within the ISPA, ISP and/or PNMT assessment • Five of five (100%) contained date assessment was initiated. This information was contained within the PNMT assessment, PNMT minutes, Habilitation Therapies Assessments, or PNMT minutes. • Five of five (100%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment. • Five of five (100%) identified the individual's current risk rating(s), including the current rationale. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Five of five (100%) included updated risk ratings based on the PNMT's	

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		assessment and analysis of relevant data. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Two of five (40%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy unless a full PNMT evaluation was provided. • Five of five (100%) contained assessment of current physical status. This information was contained within the PNMT minutes, the PNMT RN Assessment, and the various PNM related assessments (Habilitation, Nutrition, etc.) • Five of five (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment and/or PNMT evaluation. • Five of five (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment and/or PNMT evaluation. • Five of five (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment. • Five of five (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. • Four of five (80%) contained evaluation of current adaptive equipment. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy unless a full PNMT evaluation was provided. • Five of five (100%) contained nutritional assessment, including but not limited to history of weight and height; intake, nutritional needs, and mealtime/feeding schedule. This information was contained within the Annual Nutritional Assessment and the PNMT RN Assessment. as well as consults. • Two of five (40%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component when there was a PNMT referral to investigate impact of medication of the issue at hand unless a full PNMT evaluation was provided. • Zero of three (0%) identified residual thresholds, if enterally nourished. While the PNMT RN assessment reviewed residuals, there was no determination of thresholds that would indicate concern or potential referral back to the PNMT. • Five of five (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. • Five of five (100%) contained review of respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting.	

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		• Two of five (40%) contained evidence of review/analysis of lab work. This information was only contained when there was a full formal PNMT evaluation. • Two of five (40%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. This information was contained within the Nutritional Assessment, but there was no evidence of review of this component when there was a PNMT referral to investigate impact of medication of the issue at hand unless there was a full formal PNMT evaluation. • Five of five (100%) contained discussion as to whether existing supports were effective or appropriate. This information was contained within the PNMT RN Assessment as well as in the PNMT minutes. • Two of five (40%) contained oral hygiene status. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy. • Five of five (100%) contained evidence of observation of the individual's supports at their home and day/work programs. • Five of five (100%) contained evidence that the PNMT conducted hands-on assessment. • Five of five (100%) identified the potential causes of the individual's physical and nutritional management problems. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Five of five (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Five of five (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. This information was contained as part of the PNMT Assessment, IRRF, PNMT minutes and ISPA. • Five of five (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. This information was contained within the Habilitation Assessment as well as part of the PNMT Assessment and PNMT minutes. • Five of five (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e. revision of the individual's PNMP). • Five of five (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT. Missing from the process were clear clinical thresholds	

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		in which referral back to the PNMT and/or IDT would be appropriate. • Zero of five (0%) contained signatures with dates. This component could not be reviewed as the PNMT evaluations provided were computer file copies and did not contain the actual signatures. In order to maintain substantial compliance, BSSLC should ensure the original signed copies are provided during the next review. **Integration of PNMT Recommendations into IHCPs and/or ISPs** For three of five individuals (60%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. While 100% of the recommendations were clearly integrated as part of the ISPA and/or PNMT minutes and were included as part of the PNMT action plans, recommendations were not clearly linked or integrated into the IHCPs. That being said, tracking of recommendations appeared to be addressed through alternate methods as stated above. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In five of five individuals' plans reviewed (100%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. • In three of the three individuals (100%) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. • In five of five individuals' plans reviewed (100%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. • In five of the five individuals' plans reviewed (100%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In five of five individuals' plans reviewed (100%), the plans included the specific clinical indicators of health status to be monitored. • In five of five individuals' plans reviewed (100%), the plans defined triggers. • In five of five individuals' plans reviewed (100%), the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation for Individuals in Sample O.2: • In five of five individuals' documentation reviewed (100%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. • In five of five individuals' plans reviewed (100%), documentation was provided	

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		to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps. **<u>Individuals Discharged from the PNMT</u>** For individuals discharged by the PNMT in Sample O.2: ▪ Five of five individuals (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ Five of five individuals' (100%) discharge summary/action plan provided objective clinical data to justify the discharge. ▪ Five of five individuals' ISPA meeting documentation (100%) provided evidence that any new recommendations were integrated into the IHCP. Recommendations were integrated as part of the PNMP, which was referenced in the IHCP; therefore, recommendations were reflected in the IHCP. ▪ Five of five individuals' ISPA documentation, PNMT minutes and/or action plan (100%) included criteria for referral back to the PNMT. Individuals who did not have individualized criteria did not have the general criteria identified in the PNMT policy included as part of the IHCP. BSSLC had a new PNMT discharge process. The process was as follows: • PNMT meets to discuss and set criteria for re-referral to the PNMT after discharge →PNMT and IDT Joint Meeting → ISPA meeting minutes to reflect D/C and criteria for re-referral to the PNMT → IHCP is updated to reflect criteria for referral to PNMT. • The PNMT would track until the revised IHCP is received with the referral criteria. This process was implemented as of September 27, 2013 and therefore was not fully reflected in the drawn sample. Per observation of the PNMT meeting, the process was observed and the Monitoring Team will review for further implementation at the next compliance visit.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for	**<u>Identification of Individuals Requiring a PNMP</u>** Appropriate disciplines were not consistently present to approve and integrate the PNMP in the ISP. No signature pages were provided for four of the annual ISPs; therefore, calculations of presence will be based on the ten ISPs that did include the signature page. • The PT attended three of ten ISPs (30%). • The OT attended five of ten ISPs (50%).	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• The SLP attended seven of ten ISPs (70%). Zero of 14 PNMPs (0%) were comprehensively reviewed by the individual's IDT in the annual ISP meeting. While the ISPs contained evidence of review, and specified the changes required to the PNMP, missing from the review was whether the PNMPs remained functional in mitigating risks associated with PNM and the evidence supporting these statements. Examples of this were noted with individuals #59 and #305. Only noting that the PNMP was reviewed or just listing the changes does not provide a general summary of whether the strategies that were included as part of the PNMP were resulting in positive outcomes and/or effectively mitigating the PNM related risks. **PNMP Format and Content** A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 17 of 17 individuals (100%) were current within the last 12 months. • PNMPs for 17 of 17 individuals (100%) included a list of all high-risk levels and individual triggers as indicated. • In 17 of 17 most current PNMPs (100%), there were large and clear color photographs with instructions. • Seventeen of 17 PNMPs (100%) listed the adaptive equipment required by the individual. Rationale regarding the need for the adaptive equipment was not present on the PNMP but was available as part of the Habilitation Therapy assessments. • In 16 of 16 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions, were provided. • In 11 of 17 PNMPs (65%), positioning was adequately described per the individuals' assessments. Individuals #59 and #305 only had information regarding the use of the chain to help determine elevation and did not contain the degree of elevation on the PNMP. Only having a description of the chain does not easily transfer should the person move to a new bed. It should be noted that BSSLC addressed this concern for the sample prior to the Monitoring Team leaving; however, this was observed to be a pervasive issue and one that should be addressed in order to move towards substantial compliance. • In 17 of 17 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 17 of 17 PNMPs (100%), bathing instructions were provided. • In 17 of 17 (100%)PNMPs, toileting-related instructions were provided, including check and change. • In 17 of 17 (100%) of the PNMPs, handling precautions or movement techniques	

#	Provision	Assessment of Status	Compliance
		were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent or N/A. • In 17 of 17 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • In 17 of 17 individuals (100%) Dining Plans were current within the last 12 months. • Six individuals (100%) had feeding tubes with no oral intake. Six of six (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 17 of 17 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. • In 11 of 11 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 11 of 11 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 11 of 11 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. • In 17 of 17 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 17 of 17 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. • Seventeen of 17 PNMPs (100%) included information related to communication (how individual communicated, how staff should communicate with individual). At times the detail was lacking on the PNMP but in these cases, there was a corresponding communication dictionary that was available that contained the needed information. **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** For 10 individuals in Sample O.1 and O.2 for whom the IDT identified changes needed to be made to the PNMP, ten ISPA meeting documentations (100%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For individuals for whom the PNMP was revised, there was supporting documentation that ten of ten individuals' revised PNMPs (100%) had been implemented.	
O4	Commencing within six months of	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs**	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	Staff did a much better job engaging in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, 17 of 23 individuals' (73%) dining plans were implemented as written. Examples of dining plans not implemented included but were not limited to: • Individual #151 was observed gulping liquids, and liquids were not provided in ½ cup increments as specified. Based on observations by the Monitoring Team: • Seven of 20 individuals' positioning plans (35%) were implemented as written. Implementation of positioning plans continued to be extremely concerning as the plans were implemented minimally and the issues noted may have a significant impact as it relates to the risk of skin breakdown as well as aspiration and pneumonia. Examples of non-implementation included: • Individual #343 was slid down in chair with the chair not tilted all the way forward as specified in the PNMP. • Individual #303 was observed without his chest strap and leaning forward, resulting in increased abdominal compression. • Individual #69 was observed leaning to her left and slid down considerably resulting in her head being wedged beneath the headrest. Three of three individuals' transfer plans (100%) were implemented as written. During one of one observations of medication administration (100%), the nurse followed procedures in the PNMP; medication observations as reported in Provision M6 also noted that nurses followed PNMPs. Furthermore, there was evidence that nurses understood PNM risk issues and took appropriate and rapid action during medication administration, and made referrals as needed. Observations by the Monitoring Team included two examples: • In Cottage B, the nurse was administering medications to an individual who started to hyperextend his head and neck when swallowing medications. The nurse asked him to look at her and he did so; this prevented the hyperextension that could have put the individual at risk for aspiration. • Another individual in Cottage B was prescribed nectar-thickened liquids with pills given whole a few at a time mixed in pudding. While attempting to swallow a few pills mixed with pudding (of which one was a large calcium pill), followed by attempting to drink the nectar-thickened liquid, he then coughed a couple of times without struggle. The individual was immediately assessed by an RN	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>according to the Respiratory Distress/Aspiration Protocol with no abnormal findings documented in the Integrated Progress Notes. The individual was referred to Habilitation Therapy for a medication observation to evaluate the size and texture of the pills administered. The Monitoring Team was provided Integrated Progress Notes and a copy of the referral to Habilitation Therapy to validate the actions taken.

<u>Knowledge of Staff Regarding PNMPs</u>
Staff Interview: Staff demonstrated improved knowledge of the Individuals' PNMPs. Based upon interviews with eight staff from Bowie, Driscoll, and Childress, knowledge of staff has continued to improve especially as it relates to positioning. Following are the numbers of staff who answered correctly and the number asked the question:

<table>
<tr><th></th><th># Asked</th><th># Correct</th><th>% Correct</th></tr>
<tr><td>Positioning:</td><td></td><td></td><td></td></tr>
<tr><td>How do you know the individual is in the correct position in their wheelchair/bed?</td><td>8</td><td>6</td><td>75%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Mealtimes:</td><td></td><td></td><td></td></tr>
<tr><td>For what reason does the individual have thickened liquids?</td><td>8</td><td>7</td><td>88%</td></tr>
<tr><td>For what reason does the individual eat a modified texture?</td><td>8</td><td>8</td><td>100%</td></tr>
<tr><td>What is the reason for the individual using a specific utensil?</td><td>8</td><td>5</td><td>63%</td></tr>
<tr><td>If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?</td><td>3</td><td>3</td><td>100%</td></tr>
<tr><td>What does the "red dot" stand for?</td><td>8</td><td>8</td><td>100%</td></tr>
</table></td><td></td></tr>
<tr><td>O5</td><td>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</td><td><u>NEO Orientation</u>
The PNM related core competencies (i.e., foundational skills) were comprehensive. NEO orientation included the following elements:
▪ Lifting and Transfers;
▪ Positioning (Alternate, wheelchair, and bathing/showering);
▪ Adaptive Equipment;
▪ PNMP orientation and implementation;
▪ Optimal Dining; and
▪ Basics of Dysphagia.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	to implement the mealtime and positioning plans that they are responsible for implementing.	Since the last compliance visit, the courses for Optimal Dining and Dysphagia were grouped to together since both topics were highly related. The above components were included as part of the four following classes: ▪ Lifting People ▪ Nutritional Management ▪ Seating and Positioning ▪ Dysphagia and Swallowing One hundred and seventy three of 195 new employees (89%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. **PNM Core Competencies for Current Staff** As of 10/8/13, 910 of 1042 current staff that require training (87%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. One hundred fifty-five of 155 staff (100%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. These staff included those who were responsible for training the following courses: ▪ Lifting People ▪ Nutritional Management ▪ Seating and Positioning ▪ Dysphagia and Swallowing **Annual Refresher Training** Five hundred and seventy two of 606 current staff (94%) that requires training had completed annual refresher competency-based training and performance check-offs within the last 12 months. Annual refresher training focused on dysphagia and lifting/transfers. **Individual-Specific Training** To assess whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team reviewed three individuals from Sample O.1 and reviewed evidence that staff working with these individuals had received all the training related to PNM. Based on that evidence and interview, the Monitoring Team determined the Facility did have a clear process in place. Staff responsible for training other staff did successfully complete competency-based	

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		training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. A formal process did not exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individual specific training prior to working with the individuals. It was the responsibility of the Home Supervisor to ensure no staff worked with the individual who had not received the training. If the pulled staff required training then the Home Supervisor would provide the needed training. Per interview with multiple Home Supervisors, understanding of this process was not consistently noted as some stated it was the PNMP Coordinator's responsibility. In order for the Facility to move towards substantial compliance, the process to ensure pulled staff is trained should be formalized in a procedure and trained to all relevant staff. A positive addition to the training process was that the Habilitation Therapy department had just implemented an additional process to train the entire PNMP after the individual's annual ISP meeting and also to train the new staff on each individual's PNMP on the staff's assigned home once they are finished with the NEO training.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Facility's System for Monitoring of Staff Competency with PNMPs** The PNMP Policy (P.2) included the frequency of the monitors for individuals at risk as well as the areas in which the monitors are expected to be completed (i.e., bath, meal, and oral care). The monitoring policy included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk • Identification of monitors and their roles and responsibilities • Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician • Inter-rater reliability schedule Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. As stated in previous reports, the monitoring forms contained a	Noncompliance

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		section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that each question was weighted equally resulting in staff being allowed to not implement the PNMP and still have a score high enough to be rated as in compliance. Due to this scoring issue, data suggesting high compliance was potentially inaccurate. BSSLC was well aware of this issue and stated that this would be addressed in the guidelines that were to be developed. An example of this would be the high compliance that BSSLC found regarding positioning versus the low rate of compliance observed by the Monitoring Team. BSSLC was well aware of this issue and stated that this would be addressed in the guidelines that were to be developed. Development of these guidelines will help ensure staff interprets questions such as question #3 on the monitoring tool, which has significant impact on the validity of data, consistently. Monitoring tools did not include adequate instructions. The State Supported Living Center Compliance Monitoring Form did not have guiding questions regarding what the staff conducting the monitoring should be considering and looking for as well as how training should be provided in the occurrence a deficiency was noted. Staff members had completed all the requirements to demonstrate competence in monitoring. PNMP Coordinators (PNMPCs) were primarily responsible for the majority of monitors completed at BSSLC. There was evidence that the PNMPCs: • Completed the necessary core training related to PNM • Were trained on Individual specific strategies • Successfully completed training on the monitoring forms • Had been validated by clinicians on completion of monitoring forms Although staff had received the necessary training to complete the forms, the forms and how they were scored were faulty and inaccurate due to the issue with question #3 on the monitoring form, which indicates compliance even if the plan is not implemented. Thirty-four of 34 staff (100%) responsible for conducting the monitoring were provided with the training needed to successfully complete the forms in a consistent and comprehensive manner. BSSLC did not have a system in place in which information regarding the completion of monitoring forms and its related data could be pulled, analyzed and trended. There was not a formal policy or procedure that outlined: ▪ How the data would be tracked and trended • If reports results would be shared with QA/QI Council • The development of corrective action plan	

#	Provision	Assessment of Status	Compliance
		A graph showing the approximate percentage of areas monitored for PNM during the months of April 2013 to September 2013 provided information as follows:	

	Bathing	Lifting/Transfer	Meal	Med Admin	Oral Care	Positioning	Snack
4/13	12%	6%	36%	18%	16%	3%	8%
5/13	14%	5%	40%	18%	11%	4%	7%
6/13	15%	5%	41%	18%	11%	4%	6%
7/13	14%	6%	40%	22%	11%	3%	6%
8/13	11%	5%	43%	18%	13%	3%	7%
9/13	11%	6%	47%	18%	10%	3%	6%

The above graph demonstrates a proportionate number of monitors being focused on all areas in which PNM difficulties are likely to be provoked. The concern noted was that less than 1% occurred during third shift and positioning, which has been a persistent concern by the Monitoring Team, was monitored with very little frequency.

Monitoring for Individuals in Samples

For individuals in Sample O.1, PNM compliance monitoring over the past three months for 17 of 17 individuals (100%), and the frequency of monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs.

For individuals in Sample O.2, PNM compliance monitoring over the past three months for five of five individuals (100%), and the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. Frequency of monitoring primarily defaulted to the risk based monitoring schedule which was as follows:

- High Risk: monitored once monthly
- Medium Risk: monitored once quarterly
- Low Risk: monitored semiannually

For the three months prior to the review, 51 of the expected 51 monitoring sessions per policy or the individuals' assessments and/or plans (100%) were completed timely. Monitoring occurred according to the scheduled identified policy and/or as individualized in the assessment and/or plan.

For the three months prior to the review, 51 of the expected 51 monitoring sessions per policy or the individuals' assessments and/or plans (100%) were completed timely.

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		For the past three months, problems were noted on seven of the 51 monitoring forms. Of these, documentation of adequate follow-up was provided on the form for seven of seven (100%). Issues noted on the monitoring form were addressed on the spot to ensure safety and issues noted with wording on the PNMPs were submitted and modified.	
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.	**IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans** Five of the five individuals' records in Sample O.2 (100%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing, or other related services (e.g., Habilitation Therapy). Zero of the 17 individuals' records in Samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QIDP monthly reviews only stated that services were provided and provided no information regarding status of the individual or if the individual had any issues related to PNM or if the plan had been revised over the past month. Seventeen of 17 individuals' records (100%) in Samples O.1 and O.2 included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. As part of the IRRF, the team identified if there was a need to implement a trigger sheet. Trigger sheets were no longer utilized as a permanent method of tracking triggers but as a way to gather data regarding what triggers may occur and therefore need to be added as part of the IHCP. Once these triggers are identified, the trigger sheet will be discontinued and the individualized triggers will transfer over to the IHCP. The transfer of these triggers to the IHCP were inconsistent although they were included as part of the IRRF as well as the PNMP. Four of 15 Trigger sheets (26%) were completed correctly. Ten of 15 Trigger sheets (67%) were reviewed at a minimum daily by the appropriate shift RN. Issues with the Aspiration Trigger Sheet included: • The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing and Case Manager's review of the trigger sheet was inconsistent.	Noncompliance

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O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	This provision was determined to be in substantial compliance. The Facility had a system in place that clearly tracked those individuals who would benefit from oral therapy. Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake. Notes were comprehensive and included all the needed information to ensure safety and track the individuals' progress. **Evaluation of Individuals who receive Enteral Nutrition** The Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Included as part of the list was the individual's home, name, type of feeding, date tube was placed, diet, and if the individual received any form of pleasure feeding. Six of six individuals who receive enteral nutrition (100%) were evaluated at a minimum annually as evidenced by review of their IRRF, ISP, Nutritional Assessment and Habilitation Therapies Assessment. Six of six individuals (100%) evaluated had an appropriate evaluation to determine the medical necessity of the tube. Medical necessity was identified as part of the Nutritional Assessment, Habilitation Assessment, as well as part of the APEN. Two of two individuals who received enteral nourishment were admitted since the last review; and were reviewed to determine the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** Six of six individuals (100%) from Sample O.3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake. Individuals who were not ready for direct oral motor therapy were noted to be provided	Substantial Compliance

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		with interventions to: • Normalize thoracic muscle tone • Improve thoracic expansion/controlled respiration • Improve abdominal tone for flexion and rotation • Increase strength and stability of long and short neck flexors • Improve strength and flexibility of the pectoral, intercostal, and latissimus muscles • Improve stability of shoulder girdle • Improve balance and strength of cervical flexor and extensor muscles One individual from Sample 0.3 was identified as potentially benefitting from oral motor treatment and two were cleared to return to some form of oral intake. The individuals who were cleared to receive some form of oral intake had a comprehensive plan outlining the pleasure or treatment feedings. These plans for pleasure foods were primarily in the form of the PNMP. Two individuals from Sample 0.3 received pleasure feedings and One individual was on a program to return to oral intake. For individuals receiving pleasure foods, the plans contained the following components: • Staff training required prior to implementation; (this consisted of PNMP training) • Staff roles and responsibilities (e.g., implementation, monitoring);(identified as part of the PNMP policy) • Time and schedule of interventions;(included as part of the PNMP) • Specific triggers for when the plan should be stopped; (included as part of the PNMP) • Milestones for progressing with the plan; (identified as part of the Pathway to Oral Intake) • Documentation requirements (method for tracking progress); and • Frequency of subsequent assessments and staff responsible (included as part of the Habilitation Therapy Assessment and/or consult) For the one individual from Sample 0.3 who was on a plan to return to oral intake, the treatment plan/consult included all of the above components. Two of two individuals' plans to return to oral eating or improve oral eating were based on the results of the IDT's discussion (100%) and were integrated in the ISP, and/or an ISPA. Two of two individual's plans for pleasure feedings were implemented in a timely	

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		manner. One of one individual's plans for return to oral intake was implemented in a timely manner. All staff responsible for implementation of these oral intake plans (100%) were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM or the treatment was provided directly by the clinician. Three of the three individuals' plans (100%) were monitored as outlined in the plan. The plans were either monitored by the attending clinician or were monitored as part the standard risk based monitoring system. The IRRF did consistently include clinical assessment data to identify an individual's potential to return to oral eating or the medical necessity of the feeding tube; this was consistently noted as part of the Habilitation Therapy assessments which was completed by the OT, PT and SLP collaboratively.	

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:** 1. BSSLC Self-Assessment, dated 9/23/13 2. BSSLC Action Plan 9/19/13 3. Section P Presentation Book 4. BSSLC Policy P.2 Physical and Occupational Therapy: Physical and Nutritional Management Plan rev: 7/13/12 5. BSSLC Policy P.1 Physical and Occupational Therapy: Habilitation Therapy Services rev: 8/5/13 Record reviews: 6. Sample P.1: Individuals #15, #38, #41, #59, #89, #138, #153, #187, #243, #305, #392, #493, #539, and #597 7. Sample P.2: Individuals #16, #19, #148, #169, #566, and #575 8. Lists of individuals: a. Who cannot feed himself or herself and notation of any changes since the last review b. Who require positioning assistance associated with swallowing activities and notation of any changes since the last review c. Who have difficulty swallowing and notation of any changes since the last review d. At high and/or medium risk for aspiration pneumonia and choking e. With choking incidents since the last compliance review f. Who had a feeding tube inserted since the last compliance review g. Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis h. Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) i. With falls in the last 6 months (date, location, type of injury) j. With chronic respiratory infections k. With chronic dehydration l. With fecal impaction m. With pressure ulcers in the last 6 months (date, location and resolution) n. With fractures in the last year (date, location of fracture, status) o. Who were non-ambulatory or require assisted ambulation p. With wheelchairs for primary mobility q. With wheelchairs for transport r. Who use Assistive Devices for ambulation (type of device) s. With orthotic/braces 9. New PNMT members since last review, including a copy of their curriculum vita; 10. Caseloads of PNMT dedicated and non-dedicated members. 11. List of medical consultants to the PNMT (e.g., medical doctor, nurse practitioner, or physician's

	assistant and PNMT meeting minutes and attendance sheets for presence and participation of a medical doctor, nurse practitioner or physician assistant, and other IDT members as needed or defined in Facility policy. 12. PNMT members and PNMT back up curriculum vitas 13. QA reports/matrix since the last compliance review 14. List of referrals to the PNMT since the last compliance visit 15. PNMT RN post hospitalization assessments completed since the last compliance visit 16. PNMT assessment template 17. PNMT Action Plan template 18. Habilitation Therapy Annual Assessment 19. Habilitation Therapy Update 20. Wheelchair/Adaptive Equipment Maintenance Log (last 6 months) 21. IRRF template 22. IHCP template 23. List of new employees since last compliance visit and their PNM related performance check offs 24. PNM Monitoring Tool template 25. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 26. For Individuals in Sample: t. All ISPs in the last 12 months u. All ISPAs in the last 6 months v. All IRRFs in the last 12 months w. All IRRF Action Plans in the last 12 months x. IHCP/Action Plan y. QDDP Monthly Reviews for the last 6 months z. PBSPs aa. Braden Scale forms bb. Annual weight graph cc. Nutrition tab, including assessments and reviews dd. HOBE assessments ee. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted ff. OT/PT assessments in the last 12 months gg. Trigger sheets completed in the last 6 months, including the current month hh. PNMPs in the last 12 months, including pictures ii. Dining Plans in the last 6 months, including pictures jj. Completed PNM-related monitoring sheets in the last three months kk. Evidence of effectiveness monitoring completed within the last six months ll. Plan for individuals who are returning to oral eating and supporting documentation for implementation of plan (i.e., staff training documentation, staff roles and responsibilities, specific triggers when the plan should be stopped; milestones for progress with the plan, documentation requirements to track progress, and frequency of subsequent assessments and

	staff responsible and monthly progress notes) mm. Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) nn. Individual notebooks (PNM section) **People Interviewed:** **1.** Kori Kelm Physical Therapist (PT), Habilitation Therapy Director **2.** Tracy Searles Physical Therapy Assistant (PTA), **3.** Christina Koehn SLP **4.** Direct Care Professionals on (2) Childress, (4) Driscoll, and (2) Bowie. **Meeting Attended/Observations:** 1. PNMT meeting 10/8/13 2. Mealtimes and transitions (Bowie, Childress, and Driscoll) 3. Daily activities on Driscoll, Childress, and Fannin
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 9/23/13 and Action Plan dated 9/19/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section P in conducting its self-assessment, the Facility: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section P. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example: Provision P.2 in the Self-Assessment did not include review of the supports related to OT/PT as p[art of the monthly QDDP review. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. o The Self-Assessment did identify the sample(s) sizes and the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. The Facility rated itself as being in compliance with three of the provisions of Section P (Provisions P.1, P.2, and P.3). This was inconsistent with the Monitoring Team's findings. The Monitoring Team found BSSLC to be in compliance with P.1 but not with P.2 through P.4.

	• Provision P.2 was found to not be in compliance due to lack of integration into the ISP, and lack of monthly review of indirect supports. • Provision P.3 was found not to be in compliance due to lack of a clear formal method to ensure staff are trained prior to working with the individuals. The Actions plans developed were felt to move BSSLC in the right direction towards compliance; however, BSSLC should continue to review the findings of the Monitor's report and revise the Action Plan as indicated to address all identified concerns.
	Summary of Monitor's Assessment: Overall, there continued to be improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at BSSLC. Assessments were much improved and did a respectable job in providing a comprehensive review of the individual. An area that saw marked improvement was the timeliness in which assessments were provided. **Provision P.1:** This provision, which had been found in substantial compliance at the last visit, remained in substantial compliance. The Habilitation Assessment addressed the majority of components needed to fully assess an individual. Areas regarding comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills were slightly below the 90% threshold but showed marked improvement since the previous review. **Provision P.2:** This provision was determined to be not in compliance. Therapy services were not consistently integrated into the ISP. There was little evidence that individual's progress was reviewed and at least monthly. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written. Individuals were observed without supportive devices and in positions that were likely to provoke concerns related to aspiration, skin breakdown and overall poor posture. A formal process did not exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. **Provision P.4:** This provision was determined to be not in compliance. Missing from policies/procedures reviewed were evidence of documentation of expectations regarding review of services and monitoring of treatment services.

#	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	This provision, which had been found in substantial compliance at the last visit, remained in substantial compliance. The Habilitation Assessment addressed the majority of components needed to fully assess an individual. Areas regarding	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills were slightly below the 90% threshold but showed marked improvement since the previous review. It should be noted that all these components continued to show improvement. As a result, the Facility has maintained the finding of Substantial Compliance Samples for this section were as follows: Sample P.1 is the same as Sample O.1 that consisted of a non-random sample of 14 individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Sample P.2 consisted of six individuals who receive direct OT/PT services that is chosen based on a review of a list of individuals receiving therapy, including the focus of the therapy. **Timeliness of Assessments** Eleven of 11 admitted individuals since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Eleven of 11 individuals (100%) identified with therapy needs received a comprehensive OT/PT assessment within 30 days of identification. Due to BSSLC providing only assessments upon admission, the Monitoring Team included the presence of assessments as meeting and surpassing compliance with this metric. Thirteen of 14 individuals' OT/PT assessments/updates in Sample P.1 (92%) were dated as having been completed at least 10 days prior to the annual ISP. Habilitation Assessments were consistently completed in a timely manner and therefore were available for review by the IDT prior to the ISP. This was much improved since the previous compliance visit when only 57% were completed in a timely manner. Fourteen of 14 assessments or updates in Sample P.1 (100%) were current within 12 months for individuals who are provided PNM supports and services.	

#	Provision	Assessment of Status	Compliance
		OT/PT Assessment Based on review of the sample of assessments, the comprehensiveness of the OT/PT assessments for Samples P.1 and P.2 were as follows: • Twenty of 20 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Twenty of 20 assessments (100%) included diagnoses and relevance to functional status. • Twenty of 20 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. • Seventeen of 20 assessments (85%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. This represented a 13% improvement since the previous compliance visit. • Seventeen of 20 individuals' OT/PT assessments (85%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. This represented a 13% improvement since the previous compliance visit. • Twenty of 20 assessments (100%) included medical history and relevance to functional status. • Twenty of 20 assessments (100%) addressed health status over the last year • Twenty of 20 assessments (100%) listed medications and potential side effects relevant to functional status. This represented a 73% improvement since the last compliance visit. • Nineteen of Twenty assessments (95%) included preferences, strengths, and needs. • Twenty of 20 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills. • Twenty of 20 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). • Nineteen of 20 assessments (95%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. This represented a 28% improvement since the last compliance visit. • Sixteen of 20 assessments (80%) included discussion of the expansion of the individual's current abilities. This represented a 36% improvement since the last compliance review. • Eighteen of 20 assessments (90%) included discussion of the individual's potential to develop new functional skills. This represented a 35%	

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		improvement since the last compliance review. • Seventeen of 20 assessments (85%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. This represented a 16% improvement since the last compliance review. • Twenty of 20 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. • Twenty of 20 assessments (100%) included a monitoring schedule. The monitoring schedule primarily listed was the default schedule that is based upon risk. • Twenty of 20 assessments (100%) included a re-assessment schedule. The reassessment schedule at BSSLC was an updated every year if receiving direct or indirect services and a comprehensive every three years for everyone. • Twenty of 20 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information was much improved as more detailed requirements were now included as part of the overall determination. • Twenty of 20 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Twenty of 20 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement." • Twenty of 20 assessments (100%) included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. • Twenty of 20 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP. Although some of the components did not meet the 90% threshold, marked improvement was clearly noted as evidenced in the increased percentages of presence. Additionally, based on an overall review and on the fact that no negative outcomes were noted that were linked to the absence of these components, it was determined by the Monitoring Team that the individuals received a comprehensive assessment. For 20 of 20 individuals (100%) for whom updates were completed, the updates provided the individuals' current status, a description of the interventions that were	

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		provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data and monitoring and re-assessment schedules.	
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.	**OT/PT Interventions** For individuals receiving OT/PT supports and services, twenty of 20 plans for Samples P.1 and P.2 (100%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. For ten of 20 individuals in Samples P.1 and P.2 (50%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Many times there was lack of integration of the Habilitation Assessment into the ISP. This represented an 11% decrease since the last compliance visit. **Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed and resulted in the following findings: • Six of six individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For six of six individuals' records (100%) reviewed, the current OT/PT assessment/consult identified the need for direct intervention with rationale. These could be annual assessments or consults completed during the year in response to changes in status or identified needs. • For six of six individuals' records (100%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT plan of service. • For zero of six individuals' records (0%), whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Clinical justification for the termination of a direct intervention plan was included as part of the discharge/final note. The problem identified was that there was no consistent ISPA meeting upon discharge to discuss final results and recommendations. There was also no evidence of review or acknowledgment by the QIDP in their monthly notes of treatment status; therefore, the Monitoring Team was unable to determine if treatment progress or discharge was shared with the rest of the IDT. **Indirect OT/PT Programs** The implementation of these plans is discussed under Section O4 for PNMPs and in	Noncompliance

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		Section S for skill acquisition plans. **<u>Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP</u>** An OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. Seventeen of 20 ISP annual meetings (85%) had a member from either OT or PT present to represent the disciplines. Ten of 20 ISPs or ISPAs (50%) integrated the OT/PT interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. ISPs simply stated that the individual had a PNMP and the IDT approved it. In eleven of twenty ISPs or ISPAs reviewed in Sample P.1 and P.2 (55%), skill acquisition programs/potential supports that had been recommended in the OT/PT assessment were present. Recommendations regarding skill acquisition programs/supports improved as part of the Habilitation Assessment; however, these recommendations were not consistently integrated into the ISP. For 0 of six individuals (0%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT direct plan of service. Five of six individuals receiving direct OT/PT Services (83%) were provided with comprehensive progress notes (IPNs) that contained each of the indicators listed below. Progress notes included the following indicators: • Contained information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). • Described the benefit of the goal to the individual. Although this indicator was not present as part of every notes entry, it was observed as part of the initial as well as discharge/final note and therefore meets the intent of this indicator. • Reported the consistency of implementation. • Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. • A comprehensive progress note was completed on at least a monthly basis. For individuals with PNMPs, for 0 of 20 individuals (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Monthly documentation from the OT and PT and/or QDDP did not	

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		include: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. The monthly QIDP note simply stated that service was provided. No more detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review.	
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.	The requirements for this section were discussed in detail with regard to Section O.5. Indirect plans are inclusive of the PNMPs since OT/PT is covered substantially in the PNMP. A formal process did not exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**<u>Monitoring System</u>** The Facility did not implement a system for the adequate monitoring of PNMPs. • See Provision O.6 The Universal Monitoring Plan (revised 1/15/13) was reviewed and included information regarding frequency of monitoring for individuals who were at a high risk of choking/aspiration. This frequency was set at once per quarter, which was a significant decrease in frequency since the last visit. Per interview with the HT Director, frequency of monitors will be once monthly for High risk and quarterly for Moderate Risk. The Facility did not have a comprehensive OT/PT policy. The policy included the following elements: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs;	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Includes re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identifies the frequency of assessments; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services Missing from policies/procedures reviewed were elements that: • Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual. These areas are related to issues noted earlier in Section P regarding lack of monthly monitoring and/or review of services to determine the effectiveness of the supports in mitigating risks and addressing noted concerns. For 20 of 20 individuals (100%), routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Monitoring data logs provided to the Monitoring Team indicated checks of positioning devices and other adaptive equipment were included as part of the risk based PNMP monitoring. For 20 of 20 individuals (100%), positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Per review of the Wheelchair Repair Log, Individuals for whom adaptive equipment was noted to be in disrepair or needing replacement (100%), equipment was repaired or replaced within 30 days unless justification is provided, or unless the issue impacts the individual's health or safety, then action was taken within 48 hours.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment 9/23/2013 2. BSSLC Action Plan 9/19/2013 3. Presentation Book October, 2013 4. Written document indicating dental office staffing 5. List of individuals who had not completed their annual dental examination 6. Printout of past and future six-months dental schedule report 7. Document entitled list of restorative treatment needed that has not been completed 8. List of emergency dental visits during the past six months 9. List of emergency dental exams, and treatments during the past six months 10. Most recent annual ISP and dental treatment progress record for Individuals #316, #573, #360, #255, and #32 11. Database printout entitled Individuals without dental radiographs within 12 months 12. Annual dental report and annual ISP for Individuals #160, #532, #404, #305, and #93 13. OT/PT comprehensive monitoring report, dated 4/1/2013 through 9/30/2013 14. Printout of appointment failure log for 3/4/2013 through 8/30/2013 15. List of individuals who require TIVA for oral healthcare needs 16. List of individuals who had dental evaluations and/or treatments under TIVA during the past six months 17. Written statement by the Facility indicating the average number of TIVA evaluations and/or treatments that had been provided during the past six months. 18. Facility generated document indicating the status of oral healthcare evaluations and treatments for Individuals #160, #567, #538, #239, #258, #38, #254, #272, #84, and #244 **People Interviewed:** 1. Regina Polk, DDS, Dental Director 2. Mary Anne Brett, MD (Medical Director) 3. Jennifer Pampell, RDA **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: For Provision Q.1, the self-assessment relied on data to indicate if the Facility had provided timely annual dental examinations and stated that during the review period, 109 individuals were current with their annual dental examination, and 115 individuals were not current. The Monitoring Team's review of the annual dental summaries for Individuals #160, #567, #538, #239, #258, #38, #254, #272, #318, #303, #160, #96, and #239,#84, #244, #160, #532, #404, #305, and #93, determined that 40% of Individuals had fully completed annual dental examination within 365 days, which is consistent with the findings of the self-assessment. There was no self-assessment to determine efficacy of oral hygiene and dental treatments. There was no self-assessment to assess whether all individuals were provided suction toothbrush programs, when necessary. There was no self-assessment to determine if dental radiography was provided,

	per standard of care practice; and there was no self-assessment to determine if restorative treatments were completed as necessary. For Provision Q.2, the self-assessment reported that the Facility reviewed dental policy and procedures and noted it to be current and accurate; however, the Monitoring Team was provided evidence that indicated dental policies were not current, and not complete. For example, the Facility indicated that its emergency dental policy was not current; that its policy and procedure for dental radiography was not current; and that it did not have a current policy for programs to minimize the use of sedation for dental treatments. The self-assessment did not provide a meaningful evaluation for dental appointment failures. The self-assessment reported that review of data from 3/1/2013 to 8/31/2013 indicated that dental summaries were completed and submitted for IDT review 10 days prior to the ISP, and that attendance of ISPs were recorded in the dental log; however, there was no data to support the statements. Also, there was no self-assessment as to the clinical efficacy of the annual dental summaries. The Facility should consider enhancing its self-assessment of Provision Q, by ensuring that data is collected for each self-assessment item, and that the efficacy of dental services is assessed.
	Summary of Monitor's Assessment: The Facility had recently hired a new dental director, who shared with the Monitoring Team her ambition of assisting the Facility towards compliance. At the time of this review, the Facility had made little progress from the previous reporting period, and it is anticipated, that with the support of the new dental director, the Facility will develop many processes to improve dental services. The following is a summary of issues identified by the Monitoring Team: **Provision Q.1:** Following its review for Provision Q.1, the Monitoring Team noted many persistent deficiencies that prevented the provision of necessary oral health care, and agrees with the Facility's self-assessment of noncompliance with Provision Q.1. Compliance will require that the Facility develop a robust mechanism to address dental related database elements; ensure timely and comprehensive annual evaluations; improve on its management of dental emergencies; enhance its suction toothbrush practice; ensure that dental x-rays are obtained per standard of care practice for special needs dentistry; and provide adequate staffing that will enable completion of necessary dental evaluations, treatments, and dental hygiene. In addition, although not assessed at the time of this review, the Facility must ensure that dental records are maintained and documented according to standard of care practice, and maintain a program that fosters oral health care at the living area. **Provision Q.2:** The Facility had yet to develop and implement necessary policies, procedures, guidelines, and practices to gain substantial compliance for Provision Q.2; hence, the Monitoring Team concurs with the Facility in determining noncompliance. Compliance will require that the Facility develop clinically appropriate process and programs to address the use of TIVA, develop a quality assurance program for dental services, and develop and implement a clinically relevant process to help reduce the need for sedation for dental services. In addition, the Facility must also develop a more robust method of reporting oral health care needs to the IDT, and to ISP meetings.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To assess the Facility's ability to provided necessary oral health care assessments and treatments, the Monitoring Team assessed dental administration; the provision of routine, restorative, and emergency oral health care; dental hygiene; oral hygiene provided by the living area, the use of suction toothbrushing; and dental imaging. <u>Dental Administration:</u> The Monitoring Team met with the dental director and discussed issues regarding dental administration. In addition, the Monitoring Team requested the following information: • List of all staff of all dental office staff, and: o Name of staff, and title o Indicate if full time or part time o Average number of direct care hours provided each week o Caseload (number of Individuals under the direct care of each dentist) o Documentation of all DD dentistry continuing education during the past 12 months The Facility provided a document that indicated the following: • The Facility had one dentist and one dental director. • The Facility had two full time dental hygienists. • The Facility had two-full-time dental assistants. • The Facility did not include the approximate number of hours that each staff provides actual direct care to individuals. The dental director indicated to the Monitoring Team that the Facility had purchased new dental hand-pieces, and a new dental chair. <u>Annual Dental Examinations and Routine Dental Hygiene</u> To assess the provision of routine dental services, the Monitoring Team requested the following information: • Copy of last six months and next six months appointment schedule for annual dental examinations • As of the day prior to the compliance visit, alpha list of all individuals who were <u>not</u> current with their annual dental examination by the dentist, and also a list of all individuals who had not fully completed their annual dental examination. Please include the following information: o Name o Date of previous years annual dental examination o Scheduled date for most recent dental examination	Noncompliance

#	Provision	Assessment of Status	Compliance
		The Monitoring Team was provided written documentation stating that the Facility did not have a mechanism that enables future dental scheduling beyond six months. The Facility provided an untitled document that includes names, date of previous annual dental examination, reason why the examination was not completed, and the scheduled date to complete the annual dental examination. • The list documented 81 individuals were not current with their annual dental examination. • A total of 40 out of 81 individuals (49%) not current with their annual dental examination, were pending treatment under TIVA anesthesia. • For 81 of 81 individuals not current (100%), the reason for not being current with the annual dental examination was "patient not cooperative". It should be noted, however, that additional documentation provided for Provision Q.2, of this report, indicated that only 5% of appointment failures were secondary to maladaptive behaviors, and 46% of appointment failures were secondary to either staffing or transportation related issues. • The Monitoring Team reviewed the first 15 individuals on the list of individuals who were not current with their annual dental examination, and noted that individuals were behind with their annual dental examination from one to 20 months, with an average delay of 14 months, for the 15 individuals reviewed. • Despite being significantly delayed for their annual dental examination, many individuals were not re-scheduled for their annual dental examination for many months into the future. In many cases, these were due to refusals or inability to complete examinations; the Facility had not assertively addressed the individual's refusal to come to the clinic through behavioral interventions or other means. For example: o Individual #160 was previously evaluated on 2/10/2012 and was seen for an attempted annual exam on 1/31/13; however, the individual will not been seen again until 12/20/2013. o Individual #258 was previously evaluated on 2/8/2012, and was rescheduled for appointments in April, September, and November 2013; however, the individual will not been seen until February 2014 (specific day not indicated). o Individual #413 was previously evaluated on 6/7/2012. The individual was scheduled for an attempted annual exam n 6/11/13; however, the individual will not been seen until January 2014 (specific day not indicated). Summary	

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		The Monitoring Team determined that the Facility does not have an functional dental schedule that will enable scheduling dental appoints beyond six months into the future, and that there is significant delay in providing routine dental services to individuals at the Facility. <u>Restorative dental care:</u> To assess effectiveness of the Facility's provision of restorative dental care, the Monitoring Team reviewed the following documents: • List of all pending restorative treatments • Date when the underlying condition requiring the restorative treatment was first identified • Date when the restorative treatment was completed, or date of pending treatment • Documentation why restorative treatment has not been completed • Copy of the most ISP or related document, indicating the IDT's awareness of the need for restorative treatment The Facility provided the Monitoring Team with a document entitled "List of Restorative Treatment Needed that has not been Completed". The list included Individuals #575, #400, and #281. The specific pending treatment was only indicated for one of the three individuals, Individual #281. • Individual #575 was identified as needing restorative treatment on 10/1/2012, and was scheduled for treatment on 10/24/2013, under TIVA. • Individual #400 has been pending restorative treatment since 4/8/2013; however, because of staffing shortages, and other unspecified reasons, the Individual was not provided the scheduled treatment on 8/2/2013, or 8/20/2013, and was still pending treatment at the time of this review. • Individual #281 was identified as needing "fillings" on 3/21/2013, and treatment was attempted on 7/30/2013, but because of maladaptive behavior, treatment was not provided as scheduled, and the individual is scheduled for treatment under TIVA on an unspecified day in April 2014. The Facility provided the Monitoring Team with a written statement indicating "IDT meeting are only required for extraction/TIVA". Upon review of the three examples of Individuals that had not completed their restorative dental treatments, all three examples of treatment delay were secondary to either maladaptive behavior, appointment failures, and delay in arranging treatment under TIVA. Delays related to difficulty in providing services due to interfering behaviors, as well as any issues relating to modifications in oral care, eating, or functional assessment (relative to possible problem behaviors related to pain) should require involvement of the interdisciplinary	

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		team (IDT). Summary: The Facility must ensure that significant restorative treatment issues, and delays in treatments, are reviewed by the IDT. Also, the Facility must ensure available resources to provide timely restorative treatment. <u>Dental Emergencies</u> To assess the Facility's process for managing dental emergencies, the Monitoring Team requested the following information: • List of all policies/procedures specific for "dental emergencies" • Alpha list for all dental emergency during past six months, and include: o Name o Description of dental emergency o Date, and time dental emergency was first identified • For Individuals #573, #316, #255, #360, and #321 (first five individuals on the list of dental emergency visits): o Progress notes documenting initial triage of the dental emergency (medical/or dental note) o Dental progress notes/dental records from initial evaluation through full resolution of treatment for the dental emergency (all associated note/records specific for initial and follow-up treatment for dental emergencies) o All documentation of IDT review/s, and recommendations, specific for the dental emergency The Facility provided a written document indicating that it did not have a current, Facility policy or procedure for dental emergencies. The Facility provided a computer-generated printout of "Emergency Exams/Treatment for Past six Months". The list included 21 emergency dental visits; however, 12 of the 21 emergency visits were crossed off by pen, from the computer-generated printout, without an explanation why they were crossed off. For the remaining nine emergency visits, there was handwriting documenting the type of treatment received, under the treatment received field on the printout. Because of these findings, the Monitoring Team determined that the Facility did not have an effective mechanism to track and trend dental emergency visits. The Facility provided written documentation stating that dental emergencies were not reviewed by the IDT, and did not provide IDT minutes or other documents indicating that	

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		the IDT had reviewed the dental emergency visit and assessed whether any action was needed. The Facility provided the "dental treatment and progress record" form for five individuals who were reported to have experienced a dental emergency. The Facility did not provide copies of dental progress notes (IPNs). The following is a summary of the documents provided for Individuals #316, #573, #360, #255, and #321: • The Facility did not provide copies of integrated dental progress notes (IPNs). The Facility provided the "Dental Treatment and Progress Record" form; in one out of the five examples reviewed (20%), there was an action plan that included further monitoring parameters and necessary follow-up for the dental emergency. • In zero out of five cases (0%), the dental progress record reflected the dental note's assessment and treatment of the dental emergency. In all cases, the assessment was documented in language that could not easily be interpreted by non-dental professional staff. The Facility provided dental progress notes but did not provide copies of the integrated progress notes (IPNs) for this review. • The Monitoring Team could not assess promptness of assessing dental emergencies, because there was no documentation as to when the dental emergency was initially identified by living area staff. • In zero out of five cases (0%), there was evidence to support that the IDT discussed the dental emergency. The Monitoring Team is concerned that in no cases did the IDT meet to discuss the dental emergency, even when there was a possibility of the dental issues manifesting, or contributing to severe behavioral exacerbation. The following are examples of specific concerns related to the Facility's triage of dental emergencies: • Individual #316: The Individual was referred to the dental clinic on 4/1/2013 for reportedly biting his left cheek while eating. The dental record documented left jaw swelling, and laceration of the left cheek. A clinical description of the injury was not documented; for example, estimated length and extent of the laceration was not documented, the specific location, or extent of the swelling was not documented, and there was no documentation of a pain assessment, or determination if an infection was present. Follow-up for the initial dental emergency visit occurred 18 days later, on 4/19/2013, and the only documentation provided was "no swelling present". On 6/5/2013, the Individual was once again referred to the dental clinical for "left cheek being swollen", The dental treatment and progress record documented that staff reported that the Individual "beats himself up", and the oral exam indicated that	

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		there was swelling of the left and right cheek, and a laceration on the right and left cheek. As with the previous assessment, there was no clinical description of the injury, or assessment for pain. The diagnosis was traumatic injury from "possible cheek biting or self hitting". The only treatment recommendation provided was "PT to decrease behavior and allow area to heal". The Monitoring Team has the following concerns with the overall management of this dental emergency: o There was no follow-up to the 6/5/2013 documentation provided. o Follow-up for the initial dental emergency visit did not occur for 18 days, following the initial assessment. o There was lack of informative clinical documentation describing the injury and oral examination. o There was no evidence of a pain assessment. o There was no evidence documenting that possible underlying oral health care issues, such as a dental abscess, may be manifesting pain, hence causing the behavior and self-biting. o There was no documentation to indicate that the dental emergency visits were assessed by the IDT. o The 6/5/2013 dental emergency visit was not listed on the Emergency Exam/Treatment for Past Six Months printout. • Individual #573: Was seen at the dental clinic on 10/4/2013 for evaluation of left lower cheek. The Dental Treatment and Progress Record indicated that the Individual was sent to the ER for trauma to left side of face and neck. o The clinical description of the oral exam was vague, and did not provide evidence to exclude possible underlying oral health care issues. o There was no documented assessment for pain. o There were no treatment or follow-up recommendations documented. o The Monitoring Team could not discern if the Individual had returned from the ER, and was being assessed, or if the Individual was sent to the ER following assessment by the dental clinic. • Individual #360: Was referred to the dental clinic on 5/14/2013 because of "left lower side pain". The Dental Treatment and Progress Record was very brief, and documented an "emergency visual/oral inspection", and noted "pain on left – took PA on upper molars for (Dentist), tooth brushed and applied fluoride". No further documentation was noted, and there was no dental office follow-up for the 5/14/2013 emergency dental visit. The following are some concerns of the Monitoring Team: o The clinical documentation of the oral exam was vague, and did not provide a clinical description of the oral examination. o There was no specific evaluation for pain, and the dentist did not offer pain treatment to the Individual.	

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		o There was no follow-up for the emergency dental visit. o There were no recommendations, or follow-up instructions documented for living area staff. o There was no clinical explanation given for the individual's reported pain. • Individual #255: Was seen at dental clinic on 7/29/2013 for "swollen cheek on left side". The clinical description indicated, "swollen left cheek with redness injury as from chewing, swelling is mildly (firm)." The assessment documented "traumatic chewing injury of left cheek", and the documented plan stated "recommended pt not to chew on cheek to allow healing"; staff was also recommended to inform the dental office of worsening. A follow-up dental clinic visit occurred on 8/6/2013, that documented the issue had resolved. o The Monitoring Team noted that the dental record was the only dental record reviewed for dental emergencies that documented in SOAP format, listing subjective, objective, assessment a plan. o There was no documented assessment for pain. o The clinical description was vague and did not include the anatomical location of the redness, swelling, or extent of the injury. o Monitoring instructions, and follow-up dental clinic evaluation was documented. Summary: The Monitoring Team determined that the Facility did not have a mechanism in place to appropriately track and trend dental emergencies, documented dental assessments and follow-up were not clinically adequate, assessment for dental pain was not documented, monitoring instructions for living area staff was not provided by the dental office, and the IDT did not assess dental emergencies. Also, the Facility did not have a Facility policy or procedure outlining its process for managing dental related emergency treatments. <u>Dental Radiography</u> To assess if the Facility provides dental imaging, at the level of generally acceptable standard of care, the Monitoring Team requested the following documentation: • Alpha list of all individuals who the Facility has identified as not being current with dental radiography • Alpha list of all individuals who have <u>not</u> had bitewing dental x-rays (or alternative to bitewings) within the past 24 months • Policy and/or procedure specific to dental radiography • For the first five and last five individuals on the list of individuals not having had bitewing radiographs within the past 24 months: o Reason why dental x-rays are not current	

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		o Copy of IDT minutes and/or ISP minutes, that comments on delinquent dental x-rays, and specific plan to address incomplete dental x-rays The Monitoring Team was provided a document that stated: • The database does not keep a list of those not current with dental x-rays for more then 12 months. The dental director informed the Monitoring Team that the only way to determine if radiographs were current was to conduct a chart audit. • There are no IDT minutes addressing why dental radiography is not current. Therefore, the Monitoring Team determined that the IDT does not address noncompliance issues related to necessary dental imaging studies. • The Facility did not have a current policy or procedure for its processes related to dental radiography. • The Facility indicated that the state dental database tracked if Individuals were "without dental radiographs within 12 months" (but not more then 12 months), and provide a printout copy of the database; however, the Facility could not produce a list of when the last dental radiographs were taken, and the type of dental radiographs obtained, for all individuals. Review of the database printout indicated: o The printout did not specifically indicate the type of radiographs taken in the past. For example, the database indicated the date what the last radiograph was taken, but not the specific type of radiograph. o The printout's documented explanation for the delay in obtaining dental radiographs was not explanative. For example, the Facility rationale for the delay in obtaining Individual #205 dental radiogram was "Need FMS as previous xrays not diagnostic". Summary: Monitoring Team was unable to assess the Facility's provision of dental radiography. The Facility should have an efficient mechanism to determine if dental imaging studies are current, and ensure that all individuals are current with dental radiographs, per standard of care practice, or unless contraindicated. The Facility must ensure that it maintains policy and procedure that outlines its practice of obtaining dental radiographs. <u>Oral Health Care at the Living Area</u> To assess the Facility's mechanism to ensure that oral health care needs were provided at the living area, the Monitoring Team requested the following documentation: • Oral health care plans for the first and then every fifth individual listed on the current name key, for a total of ten examples. • Evidence that oral health care treatments were routinely assessed at the living	

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		area, such as oral hygiene spot checks • Current ISP documenting oral healthcare needs The Facility did not provide copies of the individual's oral healthcare plans, or evidence that living area staff were regularly assessed to ensure proper delivery of oral healthcare at the living area. The Facility did provide copies of the annual ISP, and annual dental report, for the first ten individuals on the current name key. Review of the first five of the ten annual ISPs, and annual dental reports provided for Individuals #160, #532, #404, #305, and #93 indicated: • The ISPs specifically comment on the individual's oral health care issues, such as oral health care condition, challenges to oral health care assessments, required treatments, and necessary supports and services, in zero out of five (0%) examples. • The annual dental reports documented a comprehensive summary of the individual's oral health care issues, all necessary supports and services for oral healthcare, plan to overcome barriers obstructing the provision of necessary oral healthcare, or general prognosis in zero out of five (0%) examples. • There were no examples provided (0%) to indicate that the Facility routinely assessed the provision of oral health care, such as flossing, suction toothbrushing, and toothbrushing, at the living area. The Facility provided written documentation indicating that monitoring of staff on providing oral healthcare was not routinely done. The following are examples for some of the Monitoring Team's concerns regarding the lack of the IDTs' understanding of individuals' oral healthcare condition, challenges to oral healthcare, and necessary supports and services, as represented in the annual ISP: • Individual #160: The annual ISP did not document the Individual's oral health care issues, and only indicated that suction toothbrushing was required. The annual dental report merely stated "poor OH" and "dental risk rating high-requires sedation". • Individual #532: The annual ISP did not document any dental related issue. Specific to the individual's oral healthcare condition, the annual dental report documented "low risk rating-requires no sedation. Good OH". • Individual #404: The annual ISP only documented that "his PNMP provides instruction for oral care", and no other specific information regarding his oral health care issues. Specific to the individual's oral healthcare condition, the annual dental report stated "poor OH", and "dental risk rating high-requires TIVA. • Individual #305: The annual ISP did not document any oral healthcare issues.	

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		Specific to the Individual's oral healthcare condition, the annual dental report stated "medium-fair OH". • Individual #93: The annual ISP did not document any oral healthcare issues. Specific to the individual's oral healthcare condition, the annual dental report stated "fair OH", and "dental risk rating low-requires no sedation". Summary: The Monitoring Team is concerned that the dental office does not regularly monitor living area staff to ensure appropriate provision of oral health care at the living area. Furthermore, by review of the documents provided, the Monitoring Team remains concerned that the annual ISPs do not include a comprehensive overview of oral healthcare issues, challenges, and necessary actions to overcome barriers to providing oral healthcare services, and all necessary supports and services to ensure that appropriate oral healthcare is provided. <u>Suction Toothbrushing</u> To assess the Facility's process for providing suction toothbrushing, the Facility requested the following documentation: • Alpha list of all individuals who are provided suction toothbrushing • Alpha list of all individuals identified as needing suction toothbrushing, but not currently receiving suction toothbrushing. • For the first two and last three individuals on the list of those who are provided suction toothbrushing (Individuals #), please provide: o Copy of the most recent assessment results used to evaluate efficacy of suction toothbrushing for the individual o Copy of most recent oral health rating scale o Copy of the most recent ISP, and/or IDT minutes specific to the use of suction toothbrushing o Documentation assessing the efficacy of the use of suction toothbrush The dental director informed the Monitoring Team that the dental office did not have a formal process to routinely assess living area staff's application of suction toothbrushing. The Facility provided the Monitoring Team with a document entitled OTPT Comprehensive Monitoring Report, dated 4/1/2013 through 9/30/2013. The report was 255 pages long and include a list of more then 100 individuals, not in alphabetical order. The report documented monitoring of oral care; however, the monitoring did not assess the actual delivery of oral care, such as monitoring staff's performance when providing suction toothbrushing, or the effectiveness of suction toothbrushing. The Facility provided a written statement indicating that Individuals #238, and #41 were	

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		pending suction toothbrushing because "their suction machines are on backorder from the manufacturer". There was no documentation provided explaining how oral healthcare was being provided for these two Individuals. The Facility did not provide a policy or procedure documenting how the Facility provides on-going assessment for the possible future need for suction toothbrushing, after the initial assessment. The Monitoring Team specifically requested an alpha list of all individuals who were provided suction toothbrushing; however, the Facility provided a list, entitled Suction Toothbrushing Master List 2013 that was arranged by living area and not alphabetical. In addition, the Monitoring Team requested clinical documentation for the first two, and last three individuals on the alpha list of individuals; however, the Facility provided documents for individuals #318, #303, #160, #96, and #239, who were not the first two and last three individuals on the list provided. Furthermore, the Monitoring Team arranged the names of individuals on the list into alphabetical order, and only two examples (Individuals #96, and #160) would have met the requested criteria of being either the first two or last three on the list. Also, one example provided (Individual #239), was not even included on the Suction Toothbrushing Master List. The Monitoring Team reviewed the documents provided for individuals #96, and #239: • Individual #96 o Annual ISP, dated 8/6/2013 indicated that upon "completing the monthly review the (Individual) did not have a Suction Toothbrush SSO, but was receiving suction toothbrushing. There was no other information indicating the rationale for the use of suction toothbrushing, and associated risks and benefits was not provided. o Evidence to support that a dental professional had periodically assessed the efficacy of suction toothbrushing by living area staff was not provided. o Oral healthcare rating was determined to be good. • Individuals #160 o Annual ISP, or other supporting documentation, indicating the rationale for the use of suction toothbrushing, or associated risks and benefits was not provided. o Evidence to support that a dental professional had periodically assessed the efficacy of suction toothbrushing by living area staff was not provided. o Oral healthcare rating was determined to be good. Summary: Because the dental office professional staff did not have a process to regularly assess the	

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		living area staff's provision of suction toothbrushing; did not provide a policy or procedure on how the Facility provides on-going assessment for the possible need for suction toothbrushing, following the initial assessment; and because the Facility did not provide the clinical documentation requested, the Monitoring Team determined that the Facility did not maintain a clinically effective suction toothbrush program. <u>Conclusion</u>: The Monitoring Team noted many persistent deficiencies that prevented the provision of necessary oral health care, and agrees with the Facility's self-assessment of noncompliance with Provision Q.1. Compliance will require that the Facility develop a robust mechanism to address dental related database elements; ensure timely and comprehensive annual evaluations; improve on its management of dental emergencies; enhance its suction toothbrush practice; ensure that dental x-rays are obtained per standard of care practice for special needs dentistry; and provide adequate staffing that will enable completion of necessary dental evaluations, treatments, and dental hygiene.	

Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	To assess compliance issues for Provision Q.2, the Monitoring Team reviewed the Facility's processes related to dental Quality Assurance, issues related to dental TIVA and dental scheduling, and programs to reduce the need for dental sedation.
		
		<u>Dental Schedule:</u>
		To assess the Facility's ability to maintain an efficient and effective dental scheduling system, and to determine if all dental services are current, the Monitoring Team requested the following documentation:
		• Copy of dental schedule for past six months, and pending six month period
		  o List of all "missed" appointments and
		  ▪ Reason for missed appointment
		  ▪ Date appointment was missed
		  ▪ Date follow-up appointment was scheduled
		  ▪ Specific effort document to help mitigate future missed appointments.
		• Total number of missed dental appointments during that past six months
		• Number of missed appointment during the passed six months, from April 1, 2013
		• Total number missed
		• Total number scheduled
		• Number of missed appointments because of illness of the individual
		• Number of missed appointments because of staffing issues at the living area
		• Number of missed appointments because of staffing issues at the dental office
		• Number of missed appointments because living area forgot to transport the
			Noncompliance

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		individual to the dental clinic • Number of missed appointments because of a TIVA related issue (e.g., not enough TIVA days; another individual required that particular TIVA appointment for a dental urgency, etc) • Number of missed appointments because appropriate consent was not obtained • Number of missed appointments because of other, non-specified issues • Committee Meeting minutes, associated data, and data analysis used by the facility to improve compliance with dental services The Facility provided written documentation that Facility's electronic schedule system will not enable scheduling individuals beyond six months. The Facility provided a printout of an "appointment failure log" for 3/4/2013 through 8/30/2013. The Monitoring Team specifically requested a list of appointment failure from 4/1/2013, through 10/2/2013. The Facility did not provide the specific data requested, and the printout did not include totals for each of the categories of missed appointment failures, hence, the Monitoring Team counted each appointment failure, for each indication. Review of the appointment failure log indicated: • There were 253 missed appointments between 3/4/2013, and 8/30/2013, averaging 51 missed appointments per month. • 56 out of 253 (22%) missed appointments were secondary to staffing issues at the living area. • 13 out of 253 (5%) missed appointments were secondary to transportation related issues. • 47 out of 253 (19%) missed appointments were due to dental clinic issues, such as staffing issues at the dental clinic. • 13 out of 253 (5%) missed appointments were as a result of maladaptive behaviors • 124 out of 253 (49%) missed appointments were due to other reasons. Summary Because the Facility did not have an efficient or effective method for tracking dental appointments, and because there was no documentation regarding efforts to mitigate missed appointments, the Monitoring Team was unable to determine the efficacy of the Facility's dental scheduling process, or to determine if dental treatments were current. <u>Dental quality assurance:</u> To assess the Facility's process to monitor the quality of dental services, and develop strategies to enhance oral health care at the Facility, the Monitoring Team requested the following documents:	

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		• List of all dental QA indicators • All data, trends analysis, summaries, committee minutes, action plans, and follow-up to action plans for the Facility's dental QA process, for this reporting period The Facility provided a written document stating that dental services "does not have QA at this time". Summary: The Facility should consider developed a dental quality assurance process to assess the quality and efficacy of dental services, and to regularly assess potential adverse outcomes, such as pneumonia, behavioral exacerbation, and injuries, such as fractures, following dental procedures. <u>Pre-treatment oral sedation</u> The Facility provided written documentation that stated, "Dental does not do pre-treatment oral sedation". <u>Dental desensitization / programs to minimize the use of sedation and restraint</u> The Facility provided written documentation that stated "Dental does not have a written policy in place. Dental is currently working with psychology to develop and implement a desensitization program". <u>Total Intravenous Anesthesia (TIVA)</u> To determine the Facility's availability of providing adequate quantity of TIVA services for dental procedures, and to assess the Facility's process for ensuring safe administration of TIVA, the Monitoring Team requested the following information: • Number of TIVA hours per month available at the Facility • Number of individuals who have been provided TIVA services each month, for the past six months, beginning with 4/1/2013 • Alpha list of all individuals who require TIVA for dental services • Alpha list of all individuals who were provided TIVA for dental services during the past 12 months • For the first five and last five individuals who were provided TIVA anesthesia were requested: o Copy of TIVA records associated with the most recent use of TIVA anesthesia o Copy of all nursing notes associated with post anesthesia monitoring of the individual, following general anesthesia, once back at the living area (or infirmary) • List all individuals who were provided TIVA anesthesia during the past six	

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		months, and who were diagnosed/treated/and or hospitalized for pneumonia (any type of pneumonia). o Date that general anesthesia was provided o Date pneumonia was diagnosed/treated/or person hospitalized • Statement by the Facility's dental director indicating that all individuals who require TIVA for their oral health care needs, are afforded TIVA services for their annual dental assessments for a minimum of two dental hygiene opportunities per year, and more if clinically indicated; and for all necessary restorative treatments, without a delay in treatment of more then 14 business days. The Facility provided a document stating that a total of 30 individuals had received dental treatment under TIVA during the past six months; hence, an average of five individuals were evaluated and, or treated under TIVA, per month during the past six months. The Facility provided written documentation indicating that 17 TIVA treatments were provided, on average each month. The Facility provided written documentation stating that 89 individuals required TIVA for their oral healthcare evaluation and treatments. Given that an Individual requires at least two oral healthcare treatments per year, unless contraindicated, 89 individuals should have been evaluated and/or treated during the past six-month period. The Facility provided a written document indicating that it did not have a current policy or procedure for its current TIVA practice, and that a policy revision is pending. The Facility provided a document indicating completed evaluations and treatments for the first five, and last five individuals on the list of all individuals that require TIVA for their oral healthcare treatment (Individuals #160, #567, #538, #239, #258, #38, #254, #272, #84, and #244): • Four out of 10 (40%) were current with their annual dental examination. The remaining six out of 10 (60%) individuals were pending evaluation under TIVA. The Monitoring Team noted that for Individuals #38, #272, and #244, the next treatment scheduled for these individuals was significantly delayed. For examples o Individual #38 is scheduled to have treatment under TIVA in July 2014 o Individual #272 is scheduled to have treatment under TIVA in August 2014 o Individual #244 is scheduled to have treatment under TIVA in July 2014 • Zero out of ten (0%) of the individuals were current with their scheduled dental hygiene. • Four out of ten individuals (40%) were known to be current with their restorative oral healthcare needs; one out of ten individuals (10%) was reported	

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		not being current with their oral healthcare needs; and in five out of ten individuals (50%), restorative needs were not known, because they had not had a recent oral health examination. The Facility provided a document stating that "most hygiene appointment are every 3-4 months not under TIVA since the list is so long to try to keep the mouth clean"; which indicated that the Facility did not have adequate TIVA opportunities to provide required oral healthcare. Summary: Review of the documents provided indicated that the Facility did not maintain adequate TIVA availability to meet the needs of individuals served by the dental office. <u>Conclusion:</u> The Facility had yet to develop and implement necessary policies, procedures, guidelines, and practices to gain substantial compliance for Provision Q.2; hence, the Monitoring Team concurs with the Facility in determining noncompliance. Compliance will require that the Facility develop clinically appropriate process and programs to address the use of TIVA. In addition, the Facility must also develop a more robust method of reporting oral health care needs to the IDT and integrating oral health care supports into the ISP.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-assessment 9/23/13 2. BSSLC Action Plans 9/19/13 3. Facility Section R Presentation Book 4. BSSLC Policy R.1 Communication Services 8/7/13 5. BSSLC Communication Guidelines: Comprehensive Speech Language Pathologist (SLP) Assessment of individuals 7/2011, Augmentative Communication (AAC) vs. Behavioral Support 6/2012, AAC vs. Environmental Control (EC) 7/2012, Change in Status 6/2012, Indirect Therapy 6/2012, AAC Monitoring 6/2012 Record Reviews of Individuals: 6. Sample R.1: Individuals #43, #52, #56, 84, #93, #101, #132, #337, #398, #419, and #557 7. Sample R.2: Individuals #251, #297, #461, #521, and #546 8. Sample R.3: Individuals #163, #305, #330, and #429 9. Sample R.4: Individuals #69, #84, #337, #508, and #570 10. List of current SLPs, caseloads and ratios 11. Copies of each SLP's current license and ASHA certification 12. Continuing education and training completed by the SLPs in the past 12 months 13. Facility list of new admissions since the last review 14. Tracking log of SLP assessments completed since the last review 15. Facility list of individuals with severe language deficits 16. Facility list of individuals with PBSPs and replacement behaviors related to communication 17. PBSP minutes and attendance rosters for the past six months 18. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 19. Facility AAC screening forms 20. Facility AAC-related database reports/spreadsheets 21. Facility list of general common area AAC devices 22. Facility list of individuals receiving direct communication-related intervention plans **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA) 3. Christina Koehn MS-SLP **Meeting Attended/Observations:** 1. Daily activities on Driscoll, Fannin, and Childress, and Bowie 2. Mealtimes on Driscoll, Fannin, and Childress 23.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R dated 9/23/13 and Action Plan dated 9/19/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

	Based on a review of the Facility's Self-Assessment, with regard to Section R of the Settlement Agreement, the Facility found it was in substantial compliance with Provisions R.1 and R.2. This was inconsistent with the Monitoring Team's findings of noncompliance with Provisions R.2-R.4 and substantial compliance in Provision R.1. For Section R in conducting its self-assessment, the Facility: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section R. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example, Provision R.2 in the Self-Assessment did not address the components included as part of the Communication Assessment. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. o The Self-Assessment did identify the sample(s) sizes and the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. Overall, the Self-Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report.
	Summary of Monitor's Assessment: BSSLC continued to show improvement with Section R. Assessments remained one of the stronger aspects of the Communication Section as information regarding comparative analysis demonstrated noted improvement. Suggestions stemming from the Communication Assessment regarding the acquisition of communication related skills also showed signs of emerging. **Provision R.1:** This provision was determined to be in substantial compliance. BSSLC was at full capacity with regards to Speech Pathologists and had recently opened another position for a Speech Therapy Assistant. All Therapists were board certified and licensed to practice in the state of Texas. All Therapists had evidence of participating in continuing education that was relevant to the field of practice. **Provision R.2:** This provision was determined to be not in compliance. Individuals identified as having

	decreased communication were being provided with the needed assessments. Assessments remained one of the stronger aspects of the Communication Section but still lacked the comparative analysis piece that demonstrates improvement or decline of their health as well as communicative status. Also missing was information regarding the impact of medication on the individual's ability to communicate. **Provision R.3:** This provision was determined to be not in compliance. DCPs were not observed utilizing strategies to engage Individuals in using general area devices. Individuals receiving indirect communication supports did not have their plans reviewed at least quarterly by the QDDP. Staff responsible for implementing plans did not appear to be knowledgeable of the plans. **Provision R.4:** This provision was determined to be not in compliance. BSSLC had a monitoring process to address the presence and working condition of the AAC devices but were not consistently monitoring whether or not each device was effective and/or meaningful to the individual.

#	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.	Samples for this section are as follows: Sample R.1: Consisted of 11 Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months. Sample R.2: Consisted of five Individuals receiving direct speech services. Sample R.3: Consisted of four Individuals with a PBSP and communication deficits. Sample R.4: Consisted of five Individuals from Sample R.1 above with AAC systems Sample R.5 consisted of five individuals who received indirect speech supports/services. This provision was found to remain in substantial compliance secondary to BSSLC having sufficient and well-trained staff to develop and implement the services needed by the individuals. Additionally, BSSLC has developed another position for a dedicated PNMT SLP that would allow the other therapists to improve their focus on communication. **<u>Staffing</u>** The Facility used a reasonable process to determine what an appropriate caseload would be for SLPs at BSSLC. The process used by BSSLC in determining the need for SLPs included an analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs, and assistance from speech assistants. Such responsibilities included but were not limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		implementation of programs. The Facility provided an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience based on the process identified by the BSSLC. As of this review, BSSLC was fully staffed with five SLPs and a Speech Pathology Assistant (SPA). The SPA provided modeling and assisted in the development of plans and programs as well as assisted with the monitoring process. An additional position was just recently developed for a dedicated PNMT Speech Therapist but had not been filled as of this review. The current staffing allowed for a caseload of approximately 58 individuals, which is reasonable to conduct the daily activities and responsibilities of the SLP. **Qualifications:** Five of five positions for SLPs (100%) were filled by licensed SLPs • Five of five SLPs (100%) were licensed to practice in the state of Texas. • Five of five SLPs (100%) had evidence of ASHA certification. **Continuing Education:** Based on a review of continuing education completed in the last 12 months, five of five SLP staff (100%) had completed continuing education related to communication in an area that was relevant to the population served. Education included but was not limited to: • Dementia Therapy: The Speech Language Pathologists Guide • Evaluation and Treatment of Chronic Cough • Skilled Dementia Care **Facility Policy** A local policy/process existed that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services. BSSLC provided a set of guidelines revised in June and July 2012 that provided clear operationalized guidelines for the delivery of communication supports and services. The following components were included in this policy: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) • Outlines assessment schedule • Frequency of assessments/updates • Timelines for completion of new admission assessments	

#	Provision	Assessment of Status	Compliance
		• Timelines for completion of comprehensive assessments • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication • A process for effectiveness monitoring by the SLP. • Criteria for providing an update • Methods of tracking progress and documentation standards related to intervention plans. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution • Monitoring for the presence of communication adaptive equipment or other AAC supports/material • Monitoring for the working condition of communication adaptive equipment. • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work) • The frequency of monitoring for individuals within the established Master Communication Plan priority levels • The process for identification, training, and validation for monitors • The process of inter-rater reliability.	
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.	**Assessment Plan:** The Facility had a reasonable plan to screen all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. BSSLC provides assessments for all new admissions. Individuals at a minimum are provided with a Comprehensive Communication Assessments every three years along with an annual update should the individual be provided with direct or indirect services related to communication. The Facility did define the timeframe for the completion of communication assessments for individuals within their defined priority levels. Per review of BSSLC's Master Communication Plan, a definition of each priority level for individuals with communication needs who would benefit from the use of alternative or augmentative communication systems (AAC) was provided. Communication screenings and assessments for individuals within these priority levels had been completed in the timeframe established by the Facility. Per the BSSLC guidelines, all individuals will have received a comprehensive assessment by December 2013. Per interview, BSSLC was on schedule to complete the assessments according the master plan. **Assessments Provided**	Noncompliance

#	Provision	Assessment of Status	Compliance
		Eleven of 11 individuals in Sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. All individuals in Sample R.1 received assessments annually if the individual was provided with direct or indirect services and at least every three years for all individuals. Eleven of 11 admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. For 11 of 11 individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. Eight of eight individuals in Samples R.1 and R.2 (100%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. **Communication Assessment:** Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • Sixteen of 16 individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; • Sixteen of 16 individuals' SL assessments (92%) were dated as completed at least 10 working days prior to the annual ISP; • Five of 16 individuals' SL assessments (31%) included diagnoses and relevance of impact on communication. Although this was not consistently included in the assessment, there was evidence in the ISP meetings that all relevant diagnoses and their impact on disciplines plan of care were discussed in detail. It was also noted that the reformatted Communication Assessment contained a section specific to identifying relevant diagnoses to allow for greater ease of review. • Sixteen of 16 individuals' SL assessments (100%) included individual preferences, strengths, and needs. • Eight of 16 individuals' Communication assessments (50%) included medical history and relevance to communication. While not included in the communication assessment, discussion of medications and their impact on communication was noted as part of the IRRF. It should also be noted that the reformatted communication assessment included a section specific to this issue. • Zero of 16 individuals' Communication assessments (0%) listed medications and discussed side effects relevant to communication. While not included in the communication assessment, discussion of medications and their impact on communication was noted as part of the IRRF. It should also be noted that the reformatted communication assessment included a section specific to this issue.	

#	Provision	Assessment of Status	Compliance
		• Ten of 16 individuals' SL assessments (63%) provided documentation of how the individual's communication abilities impacted his/her risk levels. Although this information was not consistently included as part of the Communication Assessment, the ISP contained information relevant to both risk level and communication status. • Sixteen of 16 individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; • Sixteen of 16 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Sixteen of 16 individuals' SL assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; • Sixteen of 16 individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. This represented an improvement of 48%. • Sixteen of 16 individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills. This represented an improvement of 48%. • Fourteen of the 16 individuals' SL assessments (88%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification; and rationale as to whether or not the individual would benefit from AAC or EC. This represented an improvement of 68%. • Eight of 16 individuals' SL assessments (50%) offered a comparative analysis of health and functional status from the previous year. This represented an improvement of 50%. Although this information was not consistently included as part of the Communication Assessment, the ISP contained information regarding comparative health status and it was included as part of the IRRF review. Additionally, the revised communication assessment included a specific section devoted to this topic in an effort to provide ease of review and will be utilized moving forward. • Sixteen of 16 individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments • Sixteen of 16 individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This represented an improvement of 78%. • Sixteen of 16 individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff.	

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		• Sixteen of 16 individuals' SL assessments (100%) had a reassessment schedule; • Thirteen of 16 individuals' SL assessments (81%) supplied a monitoring schedule. This represented an improvement of 65%. • Sixteen of 16 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. This represented an improvement of 80%. • Sixteen of 16 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition. This represented an improvement of 16%. • Thirteen of 16 individuals' SL assessments (81%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This area was much improved. This score represented an improvement of 81%. **SLP and Psychology Collaboration:** Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs) the following was noted: • Four of four communication assessments reviewed (100%) contained evidence of review of the PBSP by the SLP. This was noted in the behavioral considerations section of the SLP assessment. • For four of four individuals (100%) communication strategies identified in the assessment were included in the PBSP. • For four of four individuals (100%) communication strategies identified in the assessment were included in the ISP. This represented an improvement of 100%. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 8/23/13 to 9/3/13, participation by a SLP was noted in 97% of the meetings. The SLPs and psychologists continued to improve collaboration on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. Behavior Services and Speech continued to use a PBSP/Communication Assessment Checklist that was designed to improve consistency between the two documents and assist in identifying areas in which there is cross over between the two disciplines.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three	**Integration of Communication in the ISP** Based on review of the ISPs for individuals in Sample R.1 and R.2 the following was noted:	Noncompliance

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	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.	• In 16 of 16 ISPs reviewed (100%) for individuals with communication needs (programs and goals, Priority 1-3 in Master Plan and/or lists identifying those with communication deficits) an SLP attended the annual ISP planning meeting, or the IDT provided adequate justification. • Fifteen of 16 ISPs reviewed (94%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. • Communication Dictionaries for 16 individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • Three of 16 ISPs reviewed (19%) included how communication interventions were to be integrated into the individual's daily routine. • Eleven of 16 ISPs reviewed (69%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not consistently developed to address identified concerns with communication. • Twelve of 16 ISPs reviewed (75%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. **Development And Implementation Of Functional Individual-Specific Assistive Communication Systems** For 16 of 16 individuals in Sample R.1 and R.2 for whom the IDT directed a revision in the communication dictionary (100%), the communication dictionary was revised within 30 days. Observations were conducted in homes with AAC systems in Sample R.4 Findings included the following: • Zero of five observations (0%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for zero of five individuals (0%) were noted to be in use in each observed setting. • AAC systems for five of five individuals (100%) were portable. • AAC systems for five of five individuals (100%) were functional. • For two of five individuals (40%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices:** Observations were completed in three homes to determine the presence and use of general use AAC devices. Findings included the following: • Three of three homes (100%) had general use AAC devices present in the	

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		common areas. • In three of three homes and other environments (100%), general use AAC devices were operational. • Eight of eight general use AAC devices (100%) noted contained clear directives on how staff should use these devices. • Seven of eight general use AAC devices (88%) noted had a clear function within that setting/situation. • Zero of eight general use AAC devices noted (0%) were used. Observations were provided in which the use of the board/devices would have been appropriate (for example: mealtimes, washing hands, oral care) but were not prompted by staff or utilized by the individuals. **Direct Communication Interventions** Review of the individuals' records from Sample R.2 showed the following: • Five of five individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For five of five individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. • For five of five individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For five of five individuals (100%), information was present regarding whether the individual showed progress with the stated goal. • For zero of five individuals (0%), a description was found of the benefit of the device and/or goal to the individual. There was no evidence that the therapist reported on a monthly basis through the provision of clinical data how the goal would support communication for the individual in their daily activities. • For five of five individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • No individuals from the sample had their therapy terminated; therefore this metric could not be measured by the Monitoring Team. • For five of five individuals (100%) progress notes contained the consistency of implementation. • For five of five individuals (100%) progress notes occurred at a minimum monthly. **Indirect Communication Supports:** Programs for individuals in Samples R.1 who received indirect communication supports	

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		were reviewed and found: • Six of eleven individuals' indirect plans (55%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. Although plans were identified in the SLP assessments as skill acquisition programs, there was no evidence of actual implementation. For example, the SLP recommended goals for Individual #419 and #56 but neither of these recommendations were developed into actual goals and monitored for progress. • For ten of eleven individuals' records (90%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For 5 out of 5 individuals in Sample R.4 (100%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. Zero of six individuals (0%) receiving indirect Speech Services (Sample R.1) were provided with comprehensive progress notes that contained each of the indicators listed below. • Quarterly documentation for zero of six individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. Review consisted of only stating that the service was provided and offered no information regarding effectiveness of supports in meeting desired outcomes. • Quarterly documentation for zero of six individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of six individuals (0%) identified consistency of implementation. • Quarterly documentation for zero of six individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. **Staff Interviews** Two of eight staff interviewed (25%) were knowledgeable of the individuals in Samples R.4 and R.5 and their communication related programs; direct support professionals had difficulty with the following questions • Stating whether the individual had an AAC system. • Whether there was a communication program. • Describing the communication program goal. • Describing the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day.	

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		Competency-Based Training and Performance Check-offs: Based on review of the NEO training curriculum and individualized training, BSSLC did develop comprehensive competency based training regarding communication services. • The training materials reviewed did address all the appropriate content areas listed below: o Methods to enhance communication o Implementation of programs o Benefits and use of AAC o Identification of non-verbal means of communication One hundred and seventy three of 195 new employees (89%) had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. **Individual-Specific Competency-Based Training** To determine whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team reviewed three individuals from Sample R.4 and reviewed evidence that staff working with these individuals had received all the training related to their communication SAP. Based on that evidence the Monitoring Team determined the Facility did have a clear process in place. Two of three individuals from Sample R.4 (67%) had evidence that staff were trained on their communication saps. The staff responsible for training other staff was a Speech Therapist and was competent to train other staff regarding implementation of the device. The Facility did have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. Staff at BSSLC responsible for training others must first be trained by the SLP prior to conducting the training themselves. Additionally, the trained staff must then be observed by the SLP training others before becoming a certified trainer. This process appeared to be working well for BSSLC as no issue was noted with regards to staff being trained in a timely manner.	
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	**Policy and Procedure** A Facility policy and/or procedures existed that describes the monitoring system for communication provision of the ISP for individuals who would benefit from AAC. The Facility policy and/or procedures included the essential components related to monitoring. See Provision R.1 for additional information.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	**Monitoring of Implementation of Communication Supports** Compliance Monitoring forms for implementation of communication supports the last six months for three individuals from Sample R.4 were reviewed and the following was found: • For five of five individuals (100%), monitoring of communication supports was outlined in the assessment. • For five of five individuals (100%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. AAC monitoring was conducted that focused on presence and working condition, but this monitoring lacked review of whether the plans/devices remained appropriate. Zero of six individuals from Sample R.1 (0%) received monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. See Provision R.3 for additional information.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment, dated 9/23/2013 2. BSSLC Action Plan 9/19/2013 3. BSSLC September 2013 Presentation notes 4. BSSLC Policies S.1, S.2, S.3, and S.4, to be implemented 10/30/2013 • BSSLC Policy S.1 Skill Acquisition Program Development • BSSLC Policy S.2 Developing and Tracking Skill Acquisition Programs • BSSLC Policy S.3 Training and Monitoring Skill acquisition Programs • BSSLC Policy S.4 Program Developer Integration into the ISP Process 5. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), Positive Behavior Support Plans (PBSPs), Structural and Functional assessments (SFAs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, skill assessments, and preference assessments. All documents were reviewed in the context of the Facility Self-Assessment and Facility Action Plan. The specific individuals included in the sample were Individuals #76, #106, #251, #263, #288, #314, #471, #483, #521, and #593. **People Interviewed:** 1. Kim Littleton – Assistant Director of Programs (ADOP) 2. Susie Johnson – Director of Residential Programs 3. Melissa Moehlmann – Director of Education and Training 4. Lynsy Meier – Program Development Coordinator 5. Terry Blackmon, PhD – Director of Behavioral Services 6. Pam Boehnemann – QIDP Coordinator 7. Direct Support Professionals: Approximately 20 staff were interviewed in Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences. **Meeting Attended/Observations:** 1. Program Implementation Committee 2. Section S Strategy Committee 3. Restraint Reduction Committee 4. Observations were conducted in the following areas: Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences.
	Facility Self-Assessment: At the time of the site visit, BSSLC reported in the Self-Assessment that no Provision was in substantial compliance with the Settlement Agreement. The Monitoring Team was in agreement with the appraisal in the Self-Assessment.

	The Facility Self-Assessment conducted at BSSLC reflected some procedures similar to those used by the Monitoring Team. For example, BSSLC did review some skill assessments and skill acquisition plans. It was not evident, however, that the Facility conducted a review sufficiently comprehensive to assess compliance with all elements of the Settlement Agreement. Furthermore, the Self-Assessment at times did not encompass all elements reviewed by the Monitoring Team. Some of the weaknesses in the Self-Assessment included the following. • In Provision S.1, although the Facility did review SAPs and PBSPs, and stated that relevant assessments were also reviewed, there was no indication which assessments were reviewed or how the review was conducted. In addition, although the Facility reported compliance ratings and percentages, it was not reported which specific elements of SAPS were rated as successful and which were not. • In Provision S.2, the review conducted by the Facility was limited to the Preference and Strengths Inventory (PSI). Assessments other than the PSI or the way assessments were used in the development of SAPs was not discussed. • In Provision S.3.a, the Facility reiterated the review and findings reported in the Self-Assessment of Provision S.1. There was no information presented concerning whether SAPs were practical or functional for the individual. The Monitoring Team suggests that the Facility review the specific procedures used by the Monitoring Team, the organization of the Monitoring Team report, and the recommendations offered within that report. This should result in a more comprehensive and accurate Self-Assessment, and increase the agreement between the Facility and the Monitoring Team in the assessment of status. In addition, a more comprehensive and accurate Self-Assessment should allow the Facility to develop Action Plans that focus upon qualitative measures and advance the Facility toward substantial compliance with the Settlement Agreement.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from October 7 2013 through October 11 2013. Record reviews continued off-site following the site visit. There were indications from the site visit and following review that the Facility had achieved progress in some areas of Section S. • The Facility had established a new Program Development Department and created the Section S Strategy Team as part of a broad effort to improve assessments and skill acquisition training. • New policies concerning skill acquisition training had been developed and implemented. • Elements of the SAPs, such as specific consequences, discriminative stimuli, the opportunity for the display of target behaviors, and documentation methodology reflected considerable improvement. • Skill acquisition programs in many cases were practical and could be implemented in the relevant environments.

	Despite these improvements, the Facility demonstrated minimal progress in several areas. • Formal task analyses were not completed as part of the development of skill acquisition programs. • The ISP, Personal Focus Assessment, and other assessments were not routinely used to identify personal needs or guide the development of skill acquisition programs. • Apart from vocational settings, minimal functional engagement for individuals living at the Facility was observed. • Community-based employment training had not expanded. Although considerable need for improvement continued at the Facility in relation to Section S, it was encouraging that considerable effort was being invested in skill acquisition training. In addition, those responsible for guiding skill acquisition training at the Facility demonstrated a variety of skills and considerable enthusiasm. If BSSLC attends to the requirements of the Settlement Agreement and evidence-based practices, there is a reasonable expectation for continued progress.

#	Provision	Assessment of Status	Compliance
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	Historical Perspective In January of 2010, a review of skill acquisition programs (SAPs) at BSSLC indicated that the Facility had provided an adequate number of training programs. Although the SAPs consistently lacked the components necessary for effective teaching, each individual was provided with several training programs in her or his ISP. Through July of 2011, each site visit reflected sufficient numbers of SAPs. During the January 2012 site visit, it was noted that BSSLC had substantially reduced the number of SAPs for each individual and had replaced the SAPs with Staff Service Objectives (SSOs) that consisted of informal strategies for supporting a skill. Based upon the available information, it appeared that the supplanting of SAPs by SSOs was counterproductive concerning the provision of effecting teaching, as well as to the achievement of compliance with the SA. The initial site visit conducted in January 2010 reflected an almost total lack of essential components in the SAPs. These same conditions were noted in July of 2010. In January 2011, a sample of the "best" SAPs was selected by BSSLC. This sample, which was limited to SAPs that had been written but not yet implemented, reflected modest improvement in SAP content. The improvement was attributed to the incorporation of the Murdoch Center Program Library into the SAP development process. Additional improvement was noted in July of 2011. The review of skill acquisition training at BSSLC In January 2012 revealed a reduction in the quality of SAPs in addition to the reduction in quantity noted above. During the July 2012 site visit, the Facility reported substantial limitations regarding skill acquisition training and SAPs. A sample of SAPs reflected substantial limitations involving excessive requirements for successful trials, a lack of precise target definitions, limited details in teaching	Noncompliance

#	Provision	Assessment of Status	Compliance
	restraint.	methodology and data collection, and an inability to identify when shaping and chaining strategies were appropriate. During the April 2013, BSSLC reported that revisions to both the SAP and ISP process had recently been implemented. A sample of 11 recent ISPs, as well as three SAPs that the Facility had identified as reflecting the best work were reviewed. Findings reflected minimal improvement in comparison with previous site visits. <u>Current Site Visit</u> At the time of the current site visit, BSSLC reported that substantial changes were being made in the development and provision of skill acquisition programming. These changes involved the creation of a Program Development Department. In addition, a Section S Strategy Team was created to guide the development of new skill acquisition training procedures and track the outcomes of the new efforts. This team was made up of the Director of Education and Training, the Director of Behavioral Services, the Director of Residential Services, the QIDP Coordinator, and the Program Development Coordinator. The Section S Strategy Team, working in conjunction with the DADS consultant, had begun the process of revising SAP practices, training staff, and establishing metrics and monitoring procedures. This included the revision of Facility policies. In a review of Policy S.1 – Skill Acquisition Program Development, it was noted that the policy involved an outline of assessment practices, the content of skill acquisition programs, the manner in which staff were to be trained, and how skill acquisition and SAP benefit would be monitored. Although the policy included various basic elements of skill acquisition training and represented an improvement in guiding the development of skill acquisition programming, certain weaknesses were noted. • The policy stipulated that all SAPs were to reflect individual preferences and required the completion of a preference assessment. The preference assessment, however, was the only assessment required by Policy S1. There was no discussion of the role of clinical assessments, adaptive skill assessments, behavior assessment or task analysis. As a result, the policy suggested that any SAP that reflected an individual's preferences and that had been recommended by the IDT would satisfy policy requirements. This section of the policy did not reflect accepted practice, which requires more robust and comprehensive assessment as part of the SAP development process. • The policy presented a requirement for a task analysis. The policy, however, stipulated the presentation of the skill in component steps or the completion of an assessment leading to such steps. Breaking a skill down into steps requires a formal assessment process known as a task analysis. A task analysis is an individualized and rigorous procedure that produces steps specific to the needs of the individual. There was no indication in the policy that the Facility recognized the requirements of a task analysis or expected a task analysis to be completed for SAPs that involved a forward- or backward-chaining methodology.	

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- The policy required that there be specific consequences for a correct response. This section, however, required a "description of how an individual will be encouraged and reinforced by the trainer for showing progress toward learning a targeted behavior or skill." Although generally correct, the language used might actually confuse those developing or implementing an SAP. A more direct and simple statement could be more effective, such as the requirement that correct responses be followed by consequences likely to strengthen the response according to relevant assessments.
- The policy included the requirement of plans for generalization and maintenance of a learned skill. The requirement did not include any stipulation for specific components of a plan or data collection or monitoring procedures that would ensure that both generalization and maintenance were evidence-based practices.

As the new approaches to skill acquisition programs had only recently begun, it was unclear as to what degree changes had been incorporated into the current SAPs. In order to determine the status of SAPs a sample of 10 individuals was selected. This sample was drawn from the most recent ISPs completed at the Facility.

<u>Use of Assessment Information in Planning Skill Acquisition</u>
Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training.

Based upon the documentation provided by BSSLC, there was little indication that the Facility had substantially improved upon the use of assessments in relation to skill acquisition training.

	01/2010	04/2013	10/2013
Skill acquisition plans are implemented to address needs identified in:			
ISP	7%	9%	10%
Adaptive skill or habilitative assessment	7%	9%	0%
Psychological assessment	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	7%	10%
Skill acquisition plans are related to the individual's preferences.	0%	29%	20%

Documentation did not reflect that individuals residing at BSSLC at the time of the current site visit were provided with a task analysis as a part of SAP development. Not all teaching procedures require a task analysis. As BSSLC used forward- and backward-chaining procedures in essentially all of the

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		SAPs, a formal task analysis would be an essential assessment. Records did reflect that each individual had been provided with skill assessment by means of the Functional Skill Assessment (FSA). Unfortunately, it was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training. • Individual #76 was provided a SAP to place headphones correctly on his head so that he could listen to music and escape noisy environments. The FSA, however, did not reflect that the individual would participate in sound-based tasks. • Individual #106 was provided an SAP to teach the use of an electric razor to shave his chin. Although the SAP indicated that the SAP was based upon the FSA, the FSA reflected only the individual's skills in relation to using a manual razor. BSSLC had included the FSA as the primary skill assessment instrument despite numerous limitations in the design and utility of the tool. For example, with Individual #76, the FSA lacked any items that pertained to the specific goals of the SAP. It is possible that by scrutinizing the results of the FSA, areas could have been identified where the FSA provided a broad and valid assessment of a skill in need of strengthening. The selection of skills to be taught, however, should not be driven by the limitations of an assessment instrument. Rather, the unique needs of the individual should guide the selection of an appropriate assessment. Documentation available at the Facility did not reflect an individual-driven assessment process. The development of SAPs requires a comprehensive and precise understanding of numerous facets of an individual's abilities and limitations. The FSA alone lacks the ability to provide such assessment and understanding. The FSA, however, could serve as the initial component to a more comprehensive assessment, helping to focus attention upon general skill areas in which the individual experienced limitations. It would then be necessary to supplement the FSA with assessments specific to the areas where skill deficits were suggested. This approach could lead to a more comprehensive understanding of the individual and lead to specific and individualized training. There was no indication in the records reviewed that such supplemental assessments were used in developing skill acquisitions programs at BSSLC. An example where such an approach would have been beneficial involved Individual #263. The skill acquisition program for this individual was designed to teach money management in the form of paying for a purchase. The FSA, the only assessment listed in the SAP, indicated the individual possessed essentially no money awareness or money management skills. There was no indication that the individual possessed the ability to understand or benefit from the skill targeted by the SAP. A more thorough assessment might have identified skills that would have been much more functional for the individual that could have been targeted by an SAP.	

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		Observations and record reviews also indicated weaknesses relating to other assessments. • All individuals included in the sample had been provided with an assessment using the Preferences and Strengths Inventory (PSI). This tool provides a subjective measure that relies upon self-report and staff observation regarding what the individual prefers in relation to residence, leisure, employment, diet, and numerous other areas. A large number of individuals living at BSSLC, and several included in the sample for Provision S1, experienced substantial deficits in communication skills. It was not evident from the preference assessments that vocal, gestural or other non-language-based communication was considered when identifying personal preferences. Furthermore, it was not evident that BSSLC had made use of other means to identify personal preference with people experiencing communication limitations, such as systematic observations by neutral staff or providing the individual systematic opportunities to select or indicate preferred items. Rather, the preference assessments for individuals with limited communication routinely consisted of general, anecdotal statements of undocumented origin that could not be verified or validated. • Although formal assessments of intelligence or adaptive skills were often completed, a substantial number of individuals had not been provided current assessments. Furthermore, for those individuals who did have current assessments, there was little indication that the findings of those assessments were utilized in identifying skill deficits or developing skill acquisition programs. o According to the BSSLC spreadsheet used for tracking intellectual assessments, 82 of 288 individuals currently living at the Facility (28.5%) had not been provided a current assessment. o Nine of the 10 individuals in the site visit sample (90%) had been provided a current intellectual assessment. No information was available for the final individual in the BSSLC tracking data. Of those nine individuals for whom data was available, the average time since the most recent intellectual assessment was 1.48 years; this was well within accepted parameters. None of the SAPs for those nine individuals (0%) referenced or reflected the intellectual assessment findings. o According to the BSSLC spreadsheet used for tracking adaptive skill assessments, 127 of 288 individuals currently living at the Facility (44.1%) had not been provided a current assessment. o Eight of the individuals in the site visit sample (80%) had been provided with a standardized assessment of adaptive skills in the past year. One individual had not had an adaptive assessment since 1990. No information was available for the final individual in the BSSLC tracking data. None of the SAPs for the nine individuals with adaptive assessments (0%) referenced or reflected the adaptive skill assessment findings. It was reported by the Facility that the rates for current assessments of intelligence and adaptive skills were decreasing. The reason for this decrease was indicated to be directives from DADS to stop such assessments.	

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		• Other disciplines and clinical specialties had also provided assessment reports as part of the ISP process. Based upon information in the ISPs, SAPs, and assessment reports, there were often discrepancies between documents. o For Individual #76, the communication assessment suggested the need for teaching the individual to request preferred activities. The SAP, however, primarily involved teaching the individual to follow requests to put on headphones. o Individual #593 was provided a SAP with the stated objective to teach him to stack boxes at work. The final step of the SAP required the individual to sort boxes by size prior to stacking: He had been on this step for at least four months according to Facility Monthly Progress Reviews. The individual's most recent vocational assessment indicated that the individual in the past did not express a preference for and did not succeed in sorting objects by size. The current SAP did not reflect consideration for the vocational assessment information. If the SAP had used more powerful reinforcement or intensive training procedures for the sorting step of the SAP, it was possible that the individual could have learned the sorting task. Based upon the information obtained as a part of the site visit, it was evident that the Facility had not provided adequate assessment relating to the development of skill acquisition programs. Furthermore, when adequate assessment had been completed, the Facility failed to use the information from those assessments in the development of SAPs. <u>Teaching New Skills</u> Teaching new skills requires the use of the same learning principles involved in changing undesired behavior. Therefore, effective skill acquisition programs require many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources, the use of formal training methods that include adequate opportunities for training and high levels of reinforcement, an evidence-based and empirical approach to teaching, valid and reliable data collection, and a sound strategy for assessing progress. When one or more of these components are lacking, the ability to provide adequate habilitation services is severely compromised. It was noted during the current site visit that considerable improvement had been achieved regarding some components of the SAPs. Although the Facility was fully successful in only three elements, the overall gains were noteworthy.	

	01/2010	04/2013	10/2013
Plan reflects development based upon a task analysis	0%	7%	0%
Behavioral objective(s)	0%	57%	50%
Operational definitions of target behavior	0%	29%	60%
Description of teaching conditions	0%	31%	30%
Schedule of implementation plans for sufficient trials for	0%	0%	0%

#	Provision	Assessment of Status				Compliance
		learning to occur				
		Relevant discriminative stimuli	0%	71%	100%	
		Specific instructions	0%	7%	50%	
		Opportunity for the target behavior to occur	0%	79%	80%	
		Specific consequences for correct response	0%	64%	100%	
		Specific consequences for incorrect response	0%	64%	100%	
		Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	20%	
		Documentation methodology	0%	57%	80%	

The Facility was fully successful in three elements, and achieved success in eight of 10 sample SAPs in a two additional areas. While this constituted a very positive step forward for the Facility, it is important to note that equal effort and diligence will be needed concerning the remaining steps in order to achieve substantial compliance.

Task analysis

Conducting a meaningful task analysis is essential to the development of a skill acquisition program. For many individuals with intellectual and developmental disabilities, tasks and behaviors must be broken down into small, discrete steps that can be more easily learned. Task analysis is the process of breaking complex tasks or skills down into smaller steps in a way most beneficial to the individual who will be provided training.

It was not evident from a review of the documentation that staff at BSSLC had a clear understanding of task analyses, chaining procedures, and skill acquisition training. Although there were numerous references to task analyses, there was no indication that any actual task analyses had been conducted. Rather, the Facility appeared to be using the term task analysis to refer to the steps in a chaining procedure without recognizing that a task analysis is the process by which those steps are identified.

As stated previously, a task analysis is primarily required if a chaining procedure is to be used in teaching a skill. As the majority of SAPs at BSSLC made use of chaining procedures, then the ability to perform a task analysis and develop a chaining methodology was essential.

Behavioral objectives

It is essential that efforts to strengthen skills include objectives comprised of observable and measurable elements of the behavior. The SAPs for individuals included in the sample reflected a modest regression by the Facility. In half the cases (50%), the goal for a training program consisted of a general statement that did not clearly indicate what specific skill was to increase or the timeframe within which success was expected. As a result, it was not evident how the objective related to the specific needs of the individual or contributed to enhancing the individual's abilities.

- For Individual #76, the objective stated that the individual was required to put on

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		headphones in 15 out of 20 trials within one year; no other period is described. The operational definition specified, however, that the progress to the next step would occur after independence was demonstrated for five consecutive training sessions. It was unclear from these statements what the specific requirements for the individual were. <u>Operational definitions</u> In order for training programs to be implemented correctly, it is imperative that the program specifically defines the behavior to be increased. This requirement informs the person implementing the program exactly what behavior the individual is expected to display. Without an operational definition, the risk of strengthening unintended behaviors and slowing the individual's acquisition of skills is increased, since different trainers may prompt and reinforce different behaviors rather than have a consistent requirement. In 40% of the skill acquisition programs reviewed, the operational definitions of training targets consisted of general statements such as stacking or complying with a request, without detail of the criteria for the desired behavior (for example, for complying, does that require that the behavior begins, or that the request is completed, and whether or not it must be done without an undesired behavior such as crying or swearing?). <u>Description of teaching conditions</u> In order for teaching programs to be implemented consistently as intended, the staff implementing those programs must be given explicit instructions including what materials are to be used, how those materials are to be arranged, where training should be conducted and how the environment should be controlled. Without such instructions, training conditions often drift or change across staff and location. As a result, training is ineffective and can strengthen the wrong behavior. Of the training programs reviewed at BSSLC during the current site visit, 70% lacked details and failed to ensure that training would be implemented consistently. This reflected essentially no change since the previous site visit. <u>Sufficient trials</u> It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities for reinforcement. Often, lower frequencies of reinforcement result in slower rates of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not compete effectively and efficiently with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at BSSLC, the teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill. <u>Specific instructions</u> As with the teaching conditions, it is necessary that training be conducted in a consistent and specific manner. Without specific instructions, the trainer may use a different prompt than was intended,	

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		offer reinforcement in a different way, or strengthen a behavior other than the behavior to be learned. In comparison with the previous site visit, the Facility demonstrated an increase of 43% in relation to providing specific instructions in the SAPs. One reason for the lack of success in relation to specific instructions was the lack of familiarity with shaping and chaining procedures demonstrated by those writing SAPs at BSSLC. In some SAPs, the teaching process was described as "general shaping". In every such example, however, the SAP included specific steps to be taught in either forward or reverse order. Shaping procedures do not have specific steps, as the teaching relies upon increasingly correct successive approximations of the final skill. If the program author could not accurately identify the procedure he or she was including in the SAP, it was unlikely that the author possessed the expertise necessary to develop adequate training instructions. <u>Documentation methodology</u> In order to determine if a skill acquisition program was successful, there must be a valid and reliable method of measuring and documenting the performance of the person being taught. The Facility achieved substantial progress in this area, increasing the percentage of SAPs that described adequate documentation procedures from 57 percent to 80 percent. Despite the improvement in the documentation procedures, the actual recording of training data remained poor. • Two of ten individuals (#106 and #593; 20%) had Monthly Progress Reviews in which the IDT noted that prompts were recorded for multiple steps within a single training session when prompts were only to be offered at the final step in which success was achieved. • The SAP for Individual #76 was implemented on 7/29/2013. As of the September Monthly Review, no data had been collected for the SAP. There were also indications that the Facility was not effectively monitoring data and individual progress. • For Individual #288, the ISP reported on 7/4/2013 that the SAP needed to be continued. The individual had demonstrated mastery of the entire task in four of four trials in June and continued to demonstrate mastery through July. • Individual #483 had remained on the final step of his dental SAP during May, June and July 2013. The level of prompted necessary for success had increased in intensity throughout that period, to the point that prompts in July were primarily physical. There were no indications in the ISP or Monthly Reviews that this situation had been discussed. It was possible that the continuation of the SAP as originally written had acquired punishing qualities. The IDT should have been made aware of the individual's status so that arrangements could have been made for further assessment.	

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		Due to the factors relating to SAP documentation, it was not evident that the Facility was able to identify and implement an effective strategy to document skill acquisition. As a result, it was generally not possible for the IDT to determine when an individual was benefiting from teaching and developing functional skills. Plan for maintenance and generalization Skill acquisition programs have the ultimate goal of increasing skills in situations outside of the teaching setting. If an individual learns to differentiate colors in the classroom, but does not exhibit that same skill at home or at work or as part of a new and more complex task being learned, then the training has not been fully successful. In order to determine if skills are being used beyond the training setting, it is important that a specific method for monitoring the skill be in place. In the skill acquisition programs reviewed at BSSLC, none included the necessary elements of such a monitoring system. Summary Based upon the information obtained from observations, record reviews and staff interviews, it was evident that the efforts by the Facility to provide skill acquisition training had improved in some areas, but overall remained inadequate. There was minimal evidence that BSSLC made use of valid and reliable assessment procedures. Furthermore, the assessment information that was available was not used to develop skill acquisition programs tailored to the unique needs of the individual. SAPs were generic and lacked the essential components for teaching. Documentation also reflected that the Facility at times had not attempted to revise or alter teaching strategies when SAP data reflected undesired responses or a lack of progress from individuals. It was of particular concern that BSSLC indicated that through self-assessment procedures that eight of 10 sampled SAPs were individualized, based upon individual preferences, and reflected the results of assessments. In conducting self-assessments, it is essential that valid and comprehensive measures be used. It is also critical that those conducting the self-assessments be trained in both the use of the assessment tools as well as the practices or skills being assessed. It was not clear that the review procedures used by the Facility were adequate to the task. If BSSLC is to make progress toward substantial compliance with the Settlement Agreement, it will be necessary to enhance the SAPs, especially concerning the more technical aspect of skill training. There was improvement in some areas. At the same time, however, there were indications that the Facility lacked expertise in relation to essential skill assessment and teaching procedures. Moving forward it will be essential that skill assessment and teaching methods more stringently adhere to principles of learning and evidence-based practices. It was reported by BSSLC that a new process initiated by the Section S Strategy Team was the review of SAPs by Dr. Terry Blackmon, the Director of Behavioral Services. Although the process was new and no reviews had yet been conducted, this was a positive effort by the Facility. Dr. Blackmon's	

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expertise would be a valuable resource in working toward evidence-based skill acquisition programs.

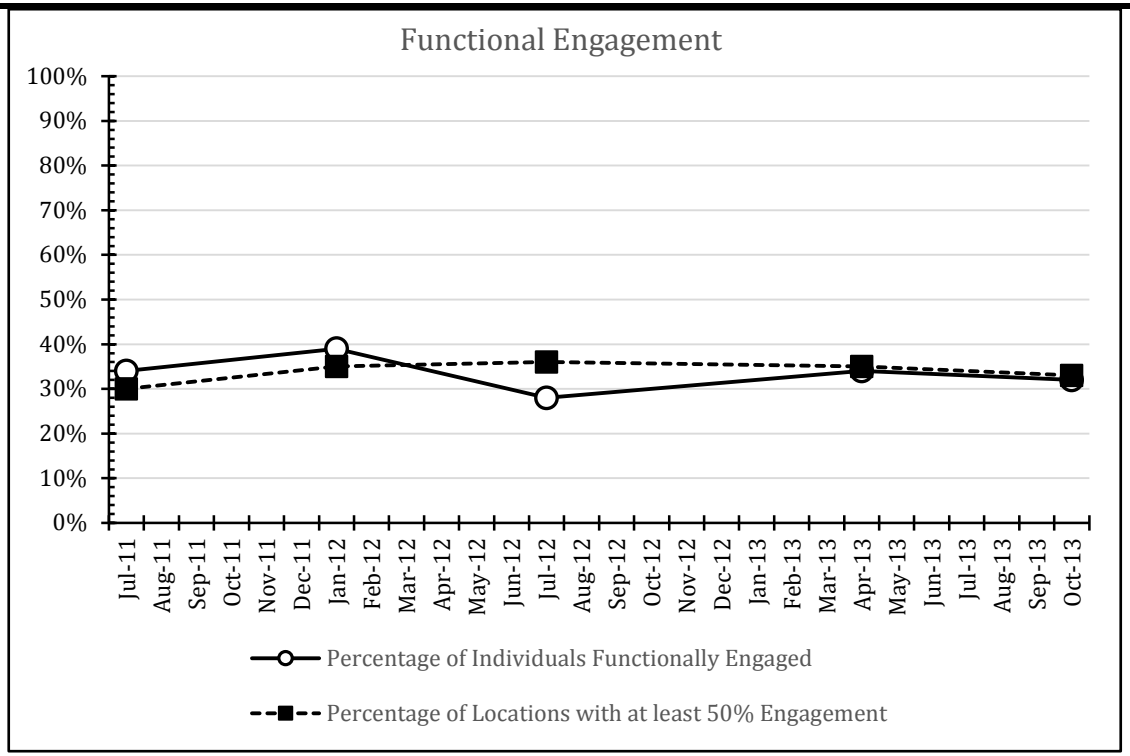
Implementation of formal and informal skill acquisition training

In addition to weaknesses relating to skill assessment and SAP development, BSSLC also demonstrated substantial limitations regarding the provision of active treatment. The Facility did have in place a system for monitoring active treatment or engagement. Despite a considerable investment of time by the Facility, however, evidence did not reflect that this system produced accurate information or resulted in adequate levels of engagement.

The Monitoring Team conducted observations in a variety of settings across the BSSLC campus. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior.

	Staff Present	Individuals Present	Individuals Functionally Engaged	Percent Functionally Engaged
Childress	1	3	0	0%
Fannin	2	2	2	100%
Fannin	2	9	0	0%
Fannin	0	1	0	0%
Fannin	4	5	0	0%
Fannin	1	1	1	100%
Childress	3	6	2	33%
Childress	4	11	4	36%
Ed	4	11	3	27%
Program Services	1	6	3	50%
Program Services	2	5	1	20%
Program Services	1	6	5	83%
	25	66	21	
Total percentage of individuals functionally engaged				32%
Percentage of locations with 50% or greater functional engagement				33%

Based upon the observations conducted during the current site visit, it was evident that overall functional engagement had decreased slightly from 34% to 32% of individuals. Observations reflected that four of the 12 observed locations (33%) reflected functional engagement for at least 50% of the individuals present during the observation. Longitudinal data involving functional engagement is presented in the graph below.

#	Provision	Assessment of Status	Compliance
		 Observations revealed that across all settings only 32% of observed individuals were functionally engaged. Furthermore, only one-third (33%) of all environments observed reflected at least 50% engagement. Specific circumstances noted during observations included the following. • In the Childress C living room, no training or activities were provided. One individual was crouched on the floor while a staff member stood over the individual. A second individual was observed crawling about the room on knees. No interruption or intervention was attempted by staff. • In the Fannin A living room, an individual was seating in a chair crying. Intermittently, the individual would begin rocking and bite his hand and wrist. Although staff were near the individual, no interruption or redirection was attempted. Not all observations conducted at BSSLC reflected low levels of functional engagement. In a few settings, staff attempted to provide the materials and attention necessary to maintain reasonable levels of functional engagement. • In Childress A, staff were working with 11 individuals, most of whom demonstrated limited attention span. The staff present were moving from individual to individual, and provided a	

#	Provision	Assessment of Status	Compliance
		variety of visual, olfactory, and auditory stimulation. Through their efforts, staff were often able to maintain the attention of the majority of the individuals at any given time. • In the Fannin D dining room, staff were observed to use verbal and gestural prompts to focus attention upon the dining activities. In addition, staff maintained social interactions with all individuals who were dining. <u>Educational Services</u> Since the previous site visit, all educational services had been relocated from BSSLC to the Brenham Independent School District. A total of 21 individuals aged 21 years and below attended public school. It was not possible to review documentation of student IEPs and other school records during the current site visit. Reports from staff, however, reflected that the individuals' performance and behavior had improved substantially since the transfer to the public schools. <u>Summary</u> Based upon information obtained from the Facility, as well as observations and document reviews, it was reflected that BSSLC had not acted with the necessary diligence to ensure that individuals were provided with adequate levels of engagement. Staff was infrequently observed to provide individualized attention or use formal prompting. BSSLC must provide the training, monitoring, and supports needed to ensure that individuals are provided with the necessary functional engagement across all settings.	
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.	Based upon a review of assessment practices, it was noted that BSSLC displayed difficulty in ensuring that individuals received complete and comprehensive assessment as part of the ISP process and training program development. Specific issues related to psychological assessments are presented in Section K of this report. A discussion of the provision and use of a variety of assessments is reflected in Provision S.1. Because of the broad weaknesses in assessment practices at BSSLC, it was not evident that the assessments provided adequate measurement of individual abilities or were likely to facilitate the skill acquisition process. Based upon this information, it was not possible to identify any areas of substantial progress in skill or preference assessment at BSSLC.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment		

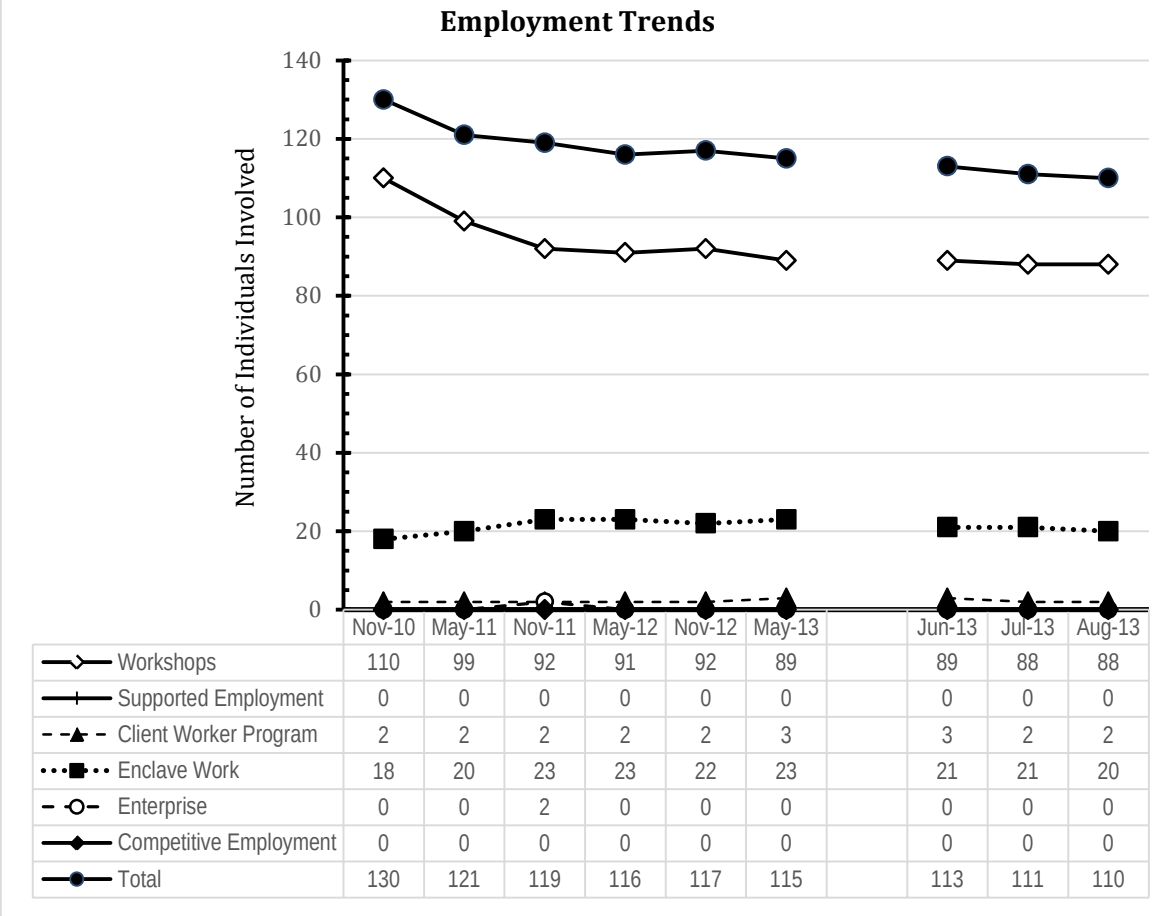
<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:</td><td></td><td></td></tr>
<tr><td></td><td>(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</td><td>Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that BSSLC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy.

It is suggested that a SAP would be practical and functional if it a) could be implemented in locations where the individual was likely to live and work, and b) was likely to strengthen the basic set of skills the individual would need to succeed. In order to obtain a measure of practical and functional qualities of the SAPs at BSSLC, the SAPs in the sample for Provision S.1 were rated on five questions. Those questions and the ratings are presented below.

<table>
<tr><th>Practical</th><th>Percentage of SAPs</th></tr>
<tr><td>SAP does not require excessive resources, time or staff.</td><td>90%</td></tr>
<tr><td>SAP is not excessively difficult or technical.</td><td>80%</td></tr>
<tr><td>SAP can be implemented in relevant environments.</td><td>100%</td></tr>
<tr><td>Functional</td><td></td></tr>
<tr><td>SAP addresses specific needs from formal assessment.</td><td>10%</td></tr>
<tr><td>SAP targets skills useful for the individual.</td><td>40%</td></tr>
</table>

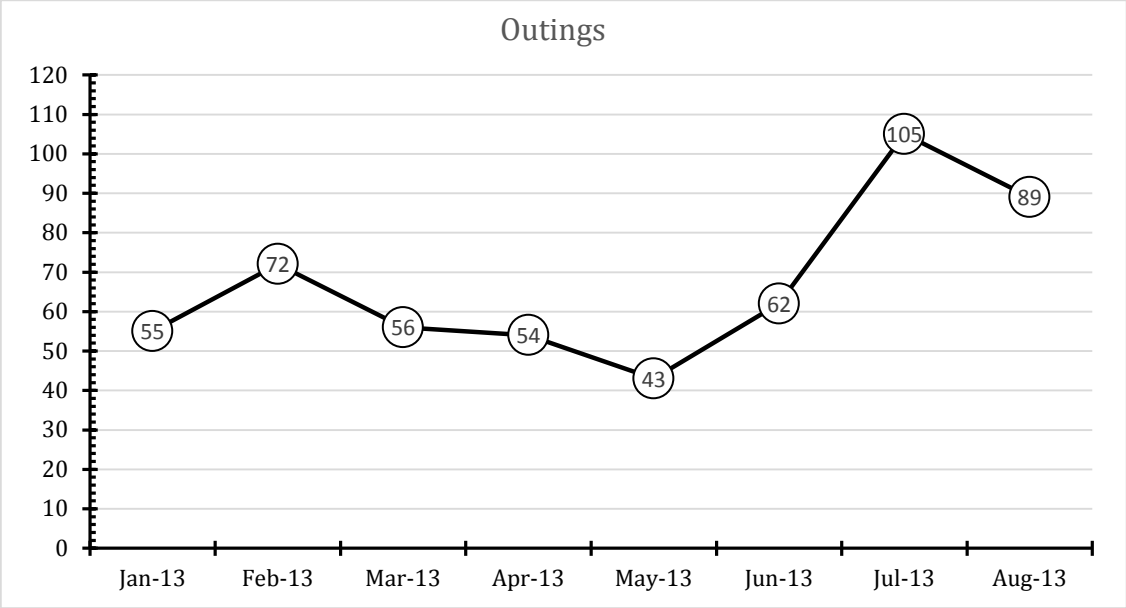
Based upon these ratings, it was suggested that the reviewed SAPs were generally practical. Examples in which SAPs were not found to be practical are presented below.
• Individual #263 was provided a SAP to teach him to exchange currency for a purchase. Although the ISP approved the training goal and a program was developed, the individual did not possess any money. The IDT therefore indicated that the program could not be implemented until the individual acquired the necessary funds.
• Individual #521 was provided a SAP to brush teeth. Based upon comments in the SAP and FSA, the individual possessed the basic brushing skills, but required better proficiency in</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		brushing all tooth surfaces. The SAP also suggested at what step the proficiency need should be addressed, but did not provide instructions on how to perform the specific shaping of the behavior. As a result, although the actual shaping would not have been overly technical, the lack of specific instructions rendered the SAP impractical. The performed ratings also suggested that the Facility experienced far greater difficulty in developing SAPs that were functional for the individual. As noted in Provision S.1, there was little evidence to support that assessments were used in the development of SAPs. It was therefore not unexpected to find that only one of the 10 SAPs (10%) was addressed needs specifically identified in the assessments. Despite the weaknesses in the use of assessments, the sample did reflect somewhat better performance in targeting skills likely to be useful to the individual, with four of the 10 SAPs (40%) rated as successful. Examples in which this was not achieved are presented below. • Individual #593 was provided a SAP to teach him to stack boxes at work. The final step of the SAP required the individual to sort boxes by size prior to stacking. The individual's most recent vocational assessment indicated that the individual in the past did not express a preference for and did not succeed in sorting objects by size. The current SAP did not emphasize the importance of the sorting task in the overall stacking skill, and did not offer accommodation for the individual's previously noted lack of interest in sorting. As adequate teaching strategies were not used in relation to the critical skill of sorting, the SAP was not functional for the individual. • It was hypothesized that Individual #76 might benefit from the use of headphones and a personal audio system to escape from noise in crowded environments. A SAP was develop that essentially involved teaching the individual to put on headphones when asked to do so. Although potentially beneficial to a degree, such a SAP also implied a dependence upon others to allow him to escape. A more functional strategy would have been to teach the individual to request or obtain from a known location a variety of tools for escaping from undesired stimuli. Based upon the information obtained during the current site visit, it was not apparent that the Facility was prepared to provide formal training that was functional for the individuals. It is recommended that the Facility enhance the integration between formal assessments and the unique needs of the individual.	
	(b) Include to the degree practicable training opportunities in community settings.	The Facility provided a breakdown of vocational opportunities provided to people living at BSSLC. As illustrated in the graph below, no progress was evidenced in any area associated with vocational opportunities. The overall opportunities for vocational services continued upon a gradual decline. No opportunities for Supported, Enterprise, or Competitive Employment were provided by BSSLC. Only the Client Worker Program were able to avoid losses in comparison with the previous site visit data.	Noncompliance

#	Provision	Assessment of Status	Compliance
			

	Nov-10	May-11	Nov-11	May-12	Nov-12	May-13	Jun-13	Jul-13	Aug-13
Workshops	110	99	92	91	92	89	89	88	88
Supported Employment	0	0	0	0	0	0	0	0	0
Client Worker Program	2	2	2	2	2	3	3	2	2
Enclave Work	18	20	23	23	22	23	21	21	20
Enterprise	0	0	2	0	0	0	0	0	0
Competitive Employment	0	0	0	0	0	0	0	0	0
Total	130	121	119	116	117	115	113	111	110

According to the Off Campus Program Tracking Log, BSSLC provided 791 outings between 1/1/2013 and 8/31/2013. A breakdown of the tracking log revealed the monthly number of outings as represented in the graph below.

#	Provision	Assessment of Status	Compliance
		 Of the 791 outings, it was reported by the Facility that 550 outings involved the implementation of skill acquisition training. A log of SAPs implemented in the community was provided, which included a goal statement and individual name for each SAP implementation listed. It was positive that the Facility had attempted to provide community skill acquisition training. An analysis of the skills being taught in the community, however, did not reveal substantial diversity in the skills being taught. The table below depicts the skill category, frequency, and percentage of total training for each skill that was taught during five separate outings or more. | Skill Category	Number of Trainings	Percentage of All Trainings
---	---	---
Toileting	5	1%
Exercise	6	1%
Dining	13	2%
Currency	21	4%
Coins	36	7%
Purchasing	48	9%
Communication	53	10%
Wash Hands	326	59%
Total	508	92%	

#	Provision	Assessment of Status	Compliance
		Based upon information provided by the Facility, 326 of 550 training sessions in the community (59%) involved hand washing. Even though clean hands are an important aspect of personal hygiene and infection control, it was not evident why the majority of trainings should target this particular skill. The money management skills of coins, currency, and purchasing together accounted for only 20% of trainings. Surprisingly, a number of vital skills were entirely absent from training, including such things as crossing streets safely, selecting and buying foods for cooking/basic preparation, locating the correct restroom, identifying police and fire stations, locating access to public transportation, asking for directions, obtaining medical care, selecting preferred entertainment options, and recognizing potential hazards. In addition to the limited number of skills being trained, it appeared that only a limited number of individuals were provided ample training opportunities. Seven individuals (Individuals #106, #234, #252, #314, #349, #367, and #425) out of 288 living at the Facility (2%) accounted for 31% of all training sessions conducted in the community. Based upon these figures, it was evident that not all individuals were provided equal access to the community or training sessions held in the community. BSSLC should be commended for the effort required to initiate a large number of community training opportunities. In order to satisfy the Settlement Agreement, however, the Facility will need to act to ensure that all individuals have equitable access to the community. In addition, the Facility, as well as the individuals living at the Facility, would benefit from an increased variety of skills to be taught. Of equal importance is the need for the Facility to ensure that skills adequately represent those abilities that will enhance independence and allow each individual to integrate with whatever community in which they choose to live.	

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Self-assessment, updated: 09/23/2013 2. BSSLC Action Plans, updated: 09/19/2013 3. BSSLC Settlement Agreement Monitoring Entrance Presentations, dated Monday, October 7, 2013 4. Section T Presentation Book 5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10 6. Draft of updated DADS Policy 018.2: Most Integrated Setting, undated 7. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/12 8. BSSLC Policy T.2: Most Integrated Setting Practices Discharges/Transfers, Revision 12/4/12, Implemented 3/27/2013 9. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 10. Since last on-site review, a list of all individuals who have been referred for placement 11. Since last on-site review, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge" 12. ISPs, ISPAs, documentation of community exploration and contact notes for individuals who had a referral rescinded in the last six months: Individuals 13. Since last on-site review, a list of all individuals who have died after moving to community living 14. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 15. For the last twelve months, a list of individuals who were reported to have been assessed for placement 16. Community Placement Report for Meeting Dates 4/1/2013-10/9/2013, dated Wednesday, October 09, 2013 17. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 18. For the last twelve months, list of all trainings/educational opportunities about community living options provided to Facility staff 19. Annual Report: Obstacles to Community Transition, Brenham State Supported Living Center, Fiscal Year 2012 20. DADS Annual Report: Obstacles to Transition Statewide Summary, issued 2/26/13 21. Community Placement Obstacles from 10/1/2012 to 9/10/2013, dated Tuesday, September 10, 2013 22. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 23. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for individuals with ISPs held in September 2013 24. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #76,

	#106, #263, #288, #314, #445, #471, #483, #521, and #593 25. Completed CLDPs for Individuals #52, #208, #252, and #490 26. Partial CLDPs for Individuals #335, #492 and #590 27. Pre Move Site Reviews for Individuals #231, #244, #260, #316, #479, #490, and #510 28. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #208, #231, #244, #252, #260, #316, #479, #490, and #510 29. Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated September 15, 2013 30. Completed Post Move Monitoring (PMM) checklists for Individuals #208, #231, #244, #252, #260, #316, #467, #479, #490, #510, and #511 31. ISPAs documenting IDT review of PMM Checklists for #208, #231, #244, #252, #260, #316, #479, #490, and #510 32. Discharge Summaries and assessments for Individuals #170, #240 and #402 **People Interviewed:** 1. Debra Green, Admissions and Placements Coordinator (APC) 2. Andrew Williams, Post-Move Monitor (PMM) 3. Daniel Dickson, Quality Assurance Director 4. Kim Littleton, Assistant Director of Programs **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #58 and #151 2. ISP Preparation Meetings for Individual #337 3. Post-Move Monitoring visit for Individual for #208
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Facility often referenced the review of Section T monitoring/auditing tools as the activity engaged in to conduct the self-assessment and as the basis for its self-rating, and often provided specific data it indicated supported that finding. In order to complete a meaningful self-assessment, however, the Facility should also develop a set of outcome indicators that it believes would be likely to lead to substantial compliance based on its own experience and on the findings and recommendations in the Monitoring Team's report. This should include the identification and evaluation of the data needed to measure these indicators. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance, including training, monitoring and assuring adherence to current policies. Once it develops provision-specific outcome indicators, the Facility should review these actions to ensure they are focusing on those most likely to support the identified outcomes. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should define the provision-specific

	outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. Sections of the Self-Assessment could reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could tie the Self-Assessment and Action Plans together. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved. This would also allow the Facility to appropriately update or modify its Action Steps based on an evaluation of outcome data. For example, the current Action Steps for Provisions T1a through T1d, as well as Provision T2a, are all designated as having been completed. Yet, the completion of the Action Steps has not resulted in substantial compliance in a number of these provisions, which would indicate additional steps may be needed. The Facility should define the provision-specific outcomes it hopes to achieve as a result of each Action Step as well as how each will be measured. **For Provision T1**, the Facility indicated it was not in full compliance with this provision, but it did report it had achieved some level of compliance for Provisions T1c1, which requires the Facility to specify in the CLDP the actions it needs to take and assistance it should obtain to implement the plan; T1c2 which requires the Facility to specify the SSLC staff responsible for CLDP actions, and the timeframes in which such actions are to be completed; T1c3, which requires the CLDP to be reviewed with the individual, and LAR as appropriate, to facilitate their decision-making; and T1h, the issuance of the Community Placement Report. The Monitoring Team concurred with Facility findings of both substantial compliance and noncompliance for Provisions T1c2, T1c3, and T1h, but did not concur for Provision T1c1. **For Provision T2**, the Facility reported it was in compliance with Provision T2a, but the Monitoring Team did not concur. The Monitoring Team found that the PMM Checklists were completed in a timely manner, but BSSLC did not yet consistently provide an adequate assessment of the presence of supports needed to assure a safe and successful transition. The Facility did not complete a self-rating in Provision T2b, as it addresses the Monitoring Team's on-site verification of the Facility's PMM processes. Noncompliance was also found for this provision. **For Provision T3,** no compliance rating is required. **For Provision T4,** the Facility indicated it was in substantial compliance but the Monitoring Team did not concur, as Discharge Summaries did not comport with Centers for Medicare and Medicaid Services (CMS) requirements.
	Summary of Monitor's Assessment: The Monitoring Team continued to find noncompliance for the Section. More work remained to ensure transitions were effectively planned and successfully implemented. A summary of noted progress included the continued impressive effort with the families of children, many of whom had previously

	expressed opposition to community living, to work toward movement to a more appropriate and integrated setting. The Monitoring Team again commends the Facility for its initiative in this area. Other positive developments noted included increased integrated discussion by Interdisciplinary Teams (IDTs) and additional augmentation of transition staffing to enhance education and awareness of community living options as well as increase the pace of transitions once a referral is made. The Monitoring Team found there was progress in the implementation of the ISP process, but significant deficits remained that continued to hamper efforts to develop and implement adequate transition planning. Other specific findings are detailed below: **For Provision T1**, nine individuals had transitioned to community living and there were ten active referrals. The Monitoring Team did find substantial compliance in several subprovisions, T1c2, T1c3 and T1h. Respectively, these addressed the identification of Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed; review of the CLDP with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living; and, the issuance of the Community Placement Report. BSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. The IDT also often failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits were apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. **For Provision T2**, the Facility reported it was in compliance with Provision T2a, but the Monitoring Team did not concur. The significant improvement in the process noted during the last visit had been sustained and the PMM Checklists continued to be completed in a timely and generally attentive manner; however, continued improvements were still needed to ensure a comprehensive review was taking place. Deficits in the adequate identification of needed supports, services and protections in the CLDP also continued to hamper the implementation of a post-move monitoring process that would serve to promote a safe and successful transition. The Monitoring Team recommends an additional layer of formalized review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months. **For Provision T3**, no rating is required. **For Provision T4**, the Facility indicated it was in substantial compliance, but the Monitoring Team did not concur. The Facility reported five Alternate Discharges during the past six months. A review of a sample of three indicated these were not routinely providing an adequate post-discharge plan of care that would assist the individual to adjust to the new living environment consistent with CMS-required discharge

	planning processes.

#	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 accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	<u>Transition Outcomes During Last Six Months:</u> • Community Transitions: The number of community transitions showed a stable or increasing trend. o There were nine transitions to community living in the last six months. With 288 individuals currently living at BSSLC, this represents approximately 3% of the population. This figure was appeared to represent a slightly increasing trend over the previous two monitoring periods for which six and eight individuals had transitioned during each six month period. o The transition process took more than 180 days for eight of the nine (89%) individuals. • Referrals for Community Transitions: o The number of community referrals indicated a decreasing trend. Seven referrals had been made in the past six months, according to the Community Placement Report for Meeting Dates 4/1/2013-10/9/2013, dated Wednesday, October 09, 2013. This compared to ten and eleven referrals made during the previous two six month periods respectively. o Ten individuals were on the active referral list (just over 3% of the current population at BSSLC). o Three of the ten (30%) individuals had been on the referral list more than 180 days; each of these three had been on the list for more than one year. • Individuals requesting placement, but were not referred: Of the three individuals who requested placement, but were not referred during the past six months, two (67%) had an LAR who made this decision. • Rescinded Referrals: o There were three rescinded referrals reported since the last review. o Of these, the reasons for the rescinding appeared to be reasonable for two (67%). For these two, the reasons for rescinding were, respectively, LAR Choice and Behavioral/Psychiatric concerns. o An adequate review was conducted to determine if changes in the referral and transition planning processes were needed at the Facility for none (0%) of the rescinded referrals, although a Special Team Review was held for one individual. For Individual #30, the IDT did develop a comprehensive plan to address the behavioral/psychiatric	Noncompliance

#	Provision	Assessment of Status	Compliance
		issues that led to the rescinded referral, but there was no clear indication as to whether these issues, which were described as historical, had somehow worsened since the referral was made six months before, nor was there any evidence provided to verify the Facility had taken any action steps toward facilitating a transition in that time period. For Individual #331, the LAR chose to rescind the referral, but the documentation did not reflect any assessment of why the LAR had changed opinion or any substantive plan to work with the LAR toward reinstating the referral. • Returns from Community Placement o One individual had returned from a community placement 30 days after transition. o This number of individuals who returned to the SSLC after a failed community placement indicated an increasing trend over the previous two monitoring site visits. o For the individual who returned to the Facility after a failed community placement, the Facility did not provide documentation that reflected an adequate review had been conducted to determine if changes in the referral and transition planning processes at the facility should be made. • Deaths Following Community Placement o One individual who moved since 7/1/09 passed away since the last onsite review. The death did not occur within the 90-day post move monitoring period. • Other Adverse Outcomes o No other significant adverse outcomes occurred during this past six months. One individual moved from the initial placement to another setting, but this was at the request of the parent. <u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:</u> During this past six months, BSSLC had taken some steps that were intended to assist IDTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. The Facility had recently hired a Placement Coordinator to augment current staffing. <u>Conclusion:</u> There was progress in this area, but the provision was found to be not yet in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 and F2ab); education for community awareness (see Provision T1b2); and	

#	Provision	Assessment of Status	Compliance
		transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not yet be said to be effectively assisting and encouraging individuals to move to the most integrated setting.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	<u>Policies and Procedures related to transition and discharge processes</u>: At parties' meetings in July 2012, the parties agreed that the Monitors would rate Provision T1b as just the development of an adequate policy. The subsections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of Provision T1b or any of the other subsections under Provision T1b. The Facility reported that it had made no changes to transition and discharge policies. There was a pending revision (018.2) of DADS Policy on Most Integrated Setting Practices, particularly related to the required formats for the CLDP, Pre-Move Site Review and PMM Checklist, which is expected to also require modifications to local policies. A draft of this policy was provided for review. As the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	<u>Protections, services, and supports:</u> DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of Section F: F1d, F2a1, and F2a3. As noted above in Section F of this report, substantial compliance was not found for Provisions F1d, F2a1, and F2a3. As documented in Provisions F1d, F2a1 and F2a3, the Monitoring Team found the IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting. Therefore, substantial compliance was not found for Provision T1b1. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> BSSLC reported it gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles. These included: • Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Lack of supports for people with significant challenging behaviors • Lack of availability of specialized therapy supports • Lack of availability of specialized medical supports • Lack of funding due to an individual's legal and citizenship status • Lack of specialized mental health supports • Need for environmental modifications to support the individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Need for services and supports for persons with forensic needs/backgrounds • Lack of specialized educational supports • Need for transportation modifications to support the individual Of ten sample ISPs reviewed, the Monitoring Team found that ten (100%) had an obstacle defined: eight indicated the only obstacle was LAR Choice and two indicated the only obstacle was Individual Choice due to lack of awareness. Plans to address these obstacles at the individual level were not adequate. Of the ten sample ISPs reviewed, none (0%) included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles). Examples included: • Individual #76 had been on a group home tour during the year and indicated in the CLOIP interview that the preference would be to live in a home. The individual's mother also stated her preference would be to have him closer to home. The IDT members found in their professional assessments that there were no obstacles to community living. Despite these findings, the IDT chose not to make a referral because there were no available homes in the mother's geographic area. Rather, the IDT indicated it would make a referral once a home became available. The ISP documented the obstacle as Individual Choice/lack of understanding of community living options. The Action Plan developed for Living Options was limited to a community outing at least monthly and opportunities to participate in provider fairs when scheduled. The failure to make a referral when the only "obstacle" was whether a home was available, and the lack of a focused Action Plan, deprived the individual and family from receiving adequate assistance from the LA and Facility toward development of an appropriate resource. It also did not accurately represent the nature of the obstacle in such a manner that it could be used by the Facility and DADS to identify resources that would need to be developed. The Monitoring Team would suggest that a new Living Options discussion be held as soon as possible to reconsider the referral and develop an appropriate Action Plan. • For Individual #471, the LAR was opposed to transition. The ISP documentation noted he said it had been 11 years since he toured community living options and that he would consider reviewing the current CLOIP materials. LAR Choice was documented as the only obstacle to living in the most integrated setting, but no Action Plan was then developed related to living options and the opportunity to assist the LAR with a thorough review of available resources. <u>Preferences of Individuals and LARs</u> Of the ten sample ISPs, none (0%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication	

#	Provision	Assessment of Status	Compliance
		style, responsiveness to educational activities). For the most part the documentation indicated the individual's preference was unknown. In neither of two annual ISP meetings observed (0%) was the individual's preference for where to live adequately described, but for Individual #151, the QIDP did bring to the IDT's attention that the Functional Skills Assessment (FSA) and PSI indicated the individual preferred a quiet environment which would be more likely found in a small group home. This was a positive development toward using an individual's known preferences as a starting point for envisioning what community living could offer. Preferences of LARs and families for living arrangement were typically more often understood and documented. The Facility was providing some opportunities for families and LARs to learn more about community options, but these were limited, as described in Provision T1b2 below, and many families were not interested in participating in them. The annual ISP process typically did not lend itself to a comfortable discussion of community living opportunities, as described in Provision F1e.	
	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.	<u>Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices:</u> In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria: <u>An Individualized Plan For Each Individual</u>: The Facility did not yet succeed in developing individualized plans for community education and awareness. There was little progress observed in the sample of ten recent ISPs reviewed for which a referral had not been made, as well as in the two new-format ISP process meetings attended. In the ISP process itself, the Monitoring Team found there continued to be little attention devoted to careful assessment of the individual's specific need for education in this area, even when lack of awareness was identified as an obstacle to movement. For none of the ten (0%) sample ISPs reviewed was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. The Monitoring Team found that in the two ISP meetings observed there was improved discussion regarding a plan for community awareness and education, but the plans developed did not adequately address the individual's learning needs. For example, for Individual #151, the IDT agreed for the individual to participate in two community living tours in a year, which would be unlikely to promote any significant increased awareness. <u>An Annual Provider Fair:</u> The Facility had held its semiannual provider fair on July 19, 2013, with another scheduled for January 2014. The Facility continued to complete a survey of the participants in the fairs and use these data to vary its approaches to this activity.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Regular SSLC Meeting With Local LAs: The APC reported BSSLC staff continued to have Interagency Planning Meetings with local LAs jointly with Admission and Placement staff from Richmond State Supported Living Center to coordinate admissions and discharges. The LA Annual In-service to be held at the Facility was scheduled for October 18, 2013. Education About Community Options: BSSLC did not have a consistent or formalized plan for collecting data on specific outcomes or measures related to education about community living, nor for using such information to evaluate opportunities to improve outcomes. Examples included: • IDT Action Plans: BSSLC was not yet collecting data regarding the development and implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. It should develop a process to do so. • CLOIP: As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed a sample of 26 CLOIP Worksheets for recent ISPs. The Contract LA staff met with 15 of the 26 individuals (58%) to present information and discuss community living options. Of the 15 individuals, seven (47%) indicated that they would in fact prefer an alternative living environment. Of these seven, only one (14%) had actually participated in a tour. It was also notable that the CLOIP worksheets appeared to include much less narrative content in each section than in observed in previous monitoring visits. Tours Of Community Providers: The Facility continued to work towards a consistent, formalized process to fashion provider tours as a part of an individualized community living awareness and education plan. Nineteen tours were provided between April 9-September 3, 2013. • Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): In the past six months, the documentation provided by the Facility listed a total of 34 individuals who had participated in CLOIP community tours. As this was the only vehicle for acquainting individuals with community programs prior to a referral being made, this did not appear to provide sufficient opportunities for the 288 individuals residing at the Facility to obtain enough experience about community living to form an opinion or participate in informed decision-making. • Places chosen to visit are based on individual's specific preferences, needs, etc.: An individualized education and awareness plan should define the types of	

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		settings to which an individual may need exposure to facilitate his or her understanding of community living options. The APC's office had made arrangements for individuals who were expected to be moving out of the Brenham area to participate in CLOIP tours offered by Contract LAs in the preferred areas. This was a commendable practice that should be continued. In addition, the Facility was arranging for providers to visit residential units on the campus for individuals who could not as easily participate in the regularly-scheduled tours due to health reasons. Overall, however, there was not a consistent or formalized process described for choosing tour sites based on individual preferences and needs. • Size of tours: The number of individuals attending a single tour may have a significant impact on the learning experience for the participants, as well as the ability of staff to gauge individuals' reactions and respond appropriately to facilitate learning. The size of tours at the Facility appeared to be conducive to both individual learning and assessment of responses, averaging about two individuals participating in any given tour. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. The Facility did not provide a description of a formalized process to ensure this assessment for all individuals; however, the APC did indicate that many individuals taking tours were at the point of referral when the visits occurred and their reactions were reviewed by the IDTs making the referral. Opportunities Are Provided To Visit Friends Who Live In The Community: BSSLC indicated there continued to be some opportunities for individuals living at the Facility to visit with friends who had moved to the community. These included one individual who continued to make a monthly visit to the new home of a friend who had moved and visits by the young ladies living at the Cottages to former housemates who had transitioned. It was also reported that an individual accompanied another person who was involved in transition activities to the new home. Education Provided In Various Venues: The Facility had held regular self-advocacy meetings for adults and youth in the past, but these had been limited since the last monitoring visit, with only three meetings having taken place. A review of the minutes for the past six months did not reflect education about community living options. A Plan For Staff To Learn More About Community Options:	

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		In response to the document request for a list of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices, the Facility provided a list of types of opportunities that included the following: • Weekly CLOIP tours on Tuesdays • Semiannual Provider's Fair, including the participation of a former resident from BSSLC who attended the Provider's Fair to share how the transition into the community was successful. • An Admissions & Placement Department Newsletter • Local group homes and ICF homes--Pictures accessible for BSSLC staff to view on the facility's Shared drive • Facility staff participating in on-site visits to community homes and day habilitation programs. The Facility also reported it provided in-service on most integrated setting policy, obstacles to referral and transition, community referral and transition process to each department at BSSLC geared toward their specific needs. <u>Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories:</u> One individual who had moved to the community was in attendance at the July Provider Fair to share experiences, continuing a commendable practice reported at the last monitoring visit. The APC also reported her department had recently published the first edition of a newsletter that would highlight success stories in the future. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team commends the efforts and progress of the Facility toward promoting education and awareness. Overall, BSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness, as described in Provisions T1, F1 and F2. IDTs continued to need additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. The Facility should also consider how it could address each of the criteria in this provision to create a comprehensive coordinated plan for community living education and awareness.	

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	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.	<u>Assessment Practices Pursuant to Transition and Discharge Policies and Procedures:</u> In describing its process for assessing individuals for community living, the Facility provided the Living Options shell, attachment C to the statewide Policy 018 on Most Integrated Setting. The Facility provided a list that indicated 281 individuals had been assessed for placement in the past twelve months, pursuant to the procedures prescribed in this section. <u>Percentage of Individuals Assessed as Required:</u> The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement; therefore, the Monitoring Team found that no individuals (0%) had been adequately assessed for placement. Issues that affected the adequacy of the assessment included: • As described in Provision T1b1, the IDTs continued to lack proficiency in identifying 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 Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements as described in Provisions T1b2 and F1c. Plans to educate individuals as to community living options were not yet well-thought out, individualized or sufficient in scope in most instances. • As described in Provision F1e, each discipline's ISP assessment needed to include an opinion/recommendation regarding community living. Only 38% of the assessments for a sample of ten recent ISPs made a statement as required. • Of the 35 assessments reviewed that did offer a recommendation, eight (23%) included substantive and individualized recommendations for how the individual's needs could be met in a more integrated setting. In many cases, a template statement in the assessment shell simply indicated that the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services might be needed in the community. These findings are discussed further in Provision F1e. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team found there was not an adequate formal assessment process that included a substantive interdisciplinary evaluation and discussion.	Noncompliance

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T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	CLDP Policy and Process: The APC was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. DADS had issued a revision to the CLDP format (Form SSLC 018E, March 2013) which the Facility had begun using with the two most recent referrals. The revised format was condensed and closer to the original CLDP format used previously. It no longer documented an ongoing narrative of transition-related activity such as review of provider packets, pre-selection visits and IDT reviews. Timeliness of Development and Implementation of CLDP: The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. For the most part, the Monitoring Team was not able to evaluate whether these requirements were fulfilled, as the CLDP documents provided for review no longer provided a running account of these activities as indicated above, nor was any other documentation provided of these activities for the sample CLDPs. The Monitoring Team did review an updated Community Placement Report for Meeting Dates 4/1/2013-10/9/2013, dated Wednesday, October 09, 2013 as one measure of timeliness in implementing transitions within 180 days as policy expectations stated. • Three of the ten (30%) current referrals had exceeded the 180 days allowed in the current policy and pending revision. • Eight of the nine (89%) transitions that had occurred also exceeded 180 days. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180 day timeframe will appropriately be exceeded. Development of CLDP in coordination with the LA: A review of four completed CLDPs indicated that four (100%) CLDPs included documentation to show that the Facility worked collaboratively with the LA. In addition to participation in the referral meeting, the LA attended the CLDP meetings and completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in Provision T1e below. Conclusion: Provision T1c was found to be not in compliance. Overall, the Facility continued to make progress in terms of balancing timeliness of completing a transition with a cautious approach toward selection of the best provider for an individual. There were a number of instances in which placements did not occur within the 180-day requirement. It would also be helpful for the APC to institute and monitor a tracking list to ensure follow-up with IDTs to ensure timely actions when necessary. Coordination with the LA in the development of the CLDP did not appear to be of significant concern at this time. There did remain, however, concerns related to the adequacy of the CLDPs that were	Noncompliance

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		developed, primarily in the failure by the IDTs to adequately identify the appropriate essential (by day of move) and nonessential (following move) supports for each individual. These deficiencies are described in more detail in Provisions T1c1, T1c2, and T1c3 below.	
	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.	<u>Actions to be taken by the Facility Specified:</u> Four completed CLDPs were reviewed to assess whether they clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). • Assessment of settings by SSLC clinicians (e.g., OT/PT). • Collaboration between provider day and residential staff is ensured • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community) • Collaboration between Post-Move Monitor and Local Authority staff None of four CLDPs (0%) were found to have included all the necessary components. Positive findings included: • Four of the four CLDPs reviewed (100%) did clearly identify a set of activities to occur on the day of the move and the responsible staff member. There was no documentation that the activities did indeed occur, however. • A review of completed CLDPs indicated provider staff were typically very involved throughout the CLDP process. In four of four (100%), there was documentation of training of provider staff, visits by the individual to the provider sites and the individual's responses and provider staff attendance at the CLDP. Issues of concern found in review of these activities included the following: • Collaboration between community providers and BSSLC providers was typically not addressed other than prescribed in-service. There were no specific requirements for any clinician to communicate with a counterpart in the community, such as contact between the facility physician and community physician to ensure understanding of health care concerns and any specific actions that should occur quickly. • None of four (0%) CLDPs specified the level of training that would be provided to community provider staff or the competency to be achieved by those trained.	Noncompliance

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		Conclusion: This provision was found to be not in compliance.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Responsible staff identified for needed actions: Responsible staff by name were provided for all Pre and Post Move supports. • Four of four (100%) of reviewed CLDPs identified all Facility staff and other staff by name and/or title for each Pre and Post Move support. Completion timeframes for needed actions identified: • Four of four (100%) of reviewed CLDPs identified specific timeframes/specific dates for completion and/or implementation for each Pre and Post Move support. Conclusion: This provision was found to be in substantial compliance.	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.	Evidence of individual/LAR participation: Based on review of four CLDPs, four (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by signatures on the CLDP and narrative descriptions. Conclusion: This provision was found to be in substantial compliance.	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.	Timeliness of Assessments: The Facility reported the APC tracked the timeliness of CLDP assessments. The Monitoring Team found that, for the most part, these processes appeared to be adequate for purposes of ensuring that assessments were available and current within 45 days prior to the individual leaving the Facility. One of four CLDPs (25%), for Individual #490, was found to have assessments that were not updated within 45 days of transition. These included the OT/PT and Speech assessments, which were just a few days beyond the required timeframe, and the Audiological assessment, which was dated some nine months prior to the transition date. BSSLC also continued to need to focus its attention on whether these assessments were adequately prepared, as described below. Adequacy and Comprehensiveness of Assessments: Assessments were still not being consistently well integrated into a comprehensive assessment in a manner that allowed for the CLDP to adequately reflect the needs and supports to be provided in the community setting. In order to be considered a current	Noncompliance

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		and comprehensive assessment of needs and supports, the findings and recommendations must be accurate and reflect all significant information the IDT and the community provider would need to develop an appropriate transition plan. As described in Provision T1e below, in a review of four completed CLDPs, the Monitoring Team found that the assessments did not consistently address the services and supports needed for each individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition, few of the assessments reviewed placed any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. Examples follow. • For Individual #208, who has a diagnosis of legal blindness, the Habilitation Therapy Discharge Update provided conflicting information regarding the individual's mobility needs. It reported that an Orientation and Mobility Assessment had been completed on 7/7/12. This assessment indicated that the individual did not use the mobility cane functionally and was not safe walking unassisted outside on uneven surfaces and on stairs. The recommendation was that a sighted guide was needed in these situations. Elsewhere in the Habilitation Therapy Discharge Update it indicates variously that the individual's assistive devices include a mobility cane for use in an unfamiliar environment, that the individual is able to walk independently on all surfaces, and that the mobility cane is rarely used, but staff assist as needed in unfamiliar environments. The Factors for Community Placement noted that the individual should live in a one story home and that furnishings should remain in the same place consistently to prevent trips and falls due to the visual impairment. There was no specific mention of any mobility needs in environments outside the home, or clarification of the functional use of the mobility cane or the use of sighted guide. It referenced the Physical and Nutritional Management Plan, but his mobility needs were not adequately addressed in that document either. See Provision T1e below for a description of the negative impact on the development of pre and post-move supports. • In addition, the Monitoring Team reviewed the assessments prepared for Individual #52, whose CLDP meeting was held on 9/26/2013, in preparation for transition scheduled for 10/22/2013. The Monitoring Team found there were significant issues that could impact a safe transition to community living, particularly with regard to clinical communication of health care issues, which were not adequately addressed in the assessments nor developed into appropriate pre and/or post-move supports. These findings were shared with the APC while the Monitoring Team was on-site for use in updating the CLDP prior to transition. Examples included: o The individual was diagnosed and treated for an unspecified seizure disorder in childhood; however, since not having a reported seizure since	

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		2009, current documentation indicated that the seizure diagnosis was in question, and that the current anticonvulsant was being used for a behavioral component, and not for seizure disorder. The Monitoring Team was concerned that the accepting agency was not informed that any adjustment with the anticonvulsant medication must include careful monitoring for potential recurrence of seizures. Also, because of the lifelong diagnosis of a seizure disorder, the Individual should be followed by a community neurologist, to help further determine the appropriateness of tapering the anticonvulsant. o The etiology of osteoporosis was not discussed, and the Individual's Low parathyroid hormone level and low testosterone level from 6/14/2013, were not commented on. The nursing discharge summary indicated that there were clinical recommendations to consider low dose testosterone, 100mg every four weeks, but this was not communicated in the medical provider's discharge summary. Also, the agency was not informed of risk factors associated with osteoporosis, and treatment of osteoporosis. o The Individual was noted to have an "overactive bladder", but this clinical issue was not discussed on the CLDP. o The Individual has had at least four radiographs that indicated issues associated with chronic constipation; however, the medical provider did not comment on this condition on the CLDP. Careful monitoring of bowel movements, and signs of bowel obstruction should be regularly assessed. o The diagnosis of extrapyramidal syndrome was noted on the active problem list, but this serious condition was not commented on by the medical provider. o The accepting agency was not well informed of management strategies for the individual's known positive reaction to TB skin testing. The agency must be aware of this condition, especially prior to assessing tuberculosis. o The Individual's oral health care needs were not adequately represented on the CLDP. Challenges with providing oral health care, and the need for TIVA for all dental examinations and treatments, were not delineated on the CLDP. Most striking was that the accepting agency was not informed of needs for dental resources, including the need for TIVA at least two times per year, and a community dentist who agreed to provide services was not identified prior to discharge. <u>Conclusion:</u> This provision was found to be not in compliance. Facility action must address the adequacy of assessment practices before compliance can be achieved under this provision. Specifically, to move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of	

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		focus/priority for the next six months: • BSSLC should renew its efforts to develop an adequate quality assurance mechanism to ensure the adequacy, accuracy and comprehensiveness of assessments for use in the CLDP, as well as to support all other planning purposes for individuals at the Facility. This might include reinstituting a pre-CLDP meeting by the IDT to review the assessments to identify and resolve any discrepancies or concerns.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	<u>Identification of Pre and Post Move Supports</u>: Four CLDPs were reviewed to determine if they identified a comprehensive set of pre and post move supports, in measurable/observable terms, to be implemented, based on an evaluation of presence or absence of each of the following criteria: • The list was comprehensive and inclusive, as demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. o All safety, medical, healthcare, risk, and supervision needs were addressed. o What was important to the individual was captured in the list of Pre and Post Move supports. o The list of supports thoroughly addressed the individual's need/desire for employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of Pre and Post Move supports. o There were Pre and Post Move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. o There were Pre and Post Move supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. o Topics included in training had a corresponding Pre and Post Move support for implementation. • The wording of every Pre and Post Move support was in appropriate, measurable, and observable terms. • Every Pre and Post Move support included an adequate description of what the Post Move Monitor should look for when doing PMM (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. • Any important support identified in the assessments or during the CLDP	Noncompliance

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		meetings that was not included in the list of Pre and Post Move supports had a rationale as to why it was not included. None of four CLDPs (0%) reviewed fully met the criteria. Examples of safety, medical, healthcare, risk, and supervision needs not being addressed for Individuals #208 and #52 are described in extensive detail in Provision T1d above. In addition, for Individual #490, the Monitoring Team found that sufficient attention was not paid to the individual's past history, and recent and current behavioral and psychiatric problems. The Psychological assessment indicated the individual had a history of mouthing objects, including 16 incidents over the previous year. The nature of this behavior and the supports and protections required to keep the individual from harm as a result was not specifically addressed or adequately described in the CLDP. The accompanying behavioral plan, which was to be in-serviced to the community provider staff, did not address this behavior either. The individual returned to the Facility from community placement within 30 days, after having been hospitalized for swallowing a battery. For none of four CLDPs (0%) reviewed were there sufficient descriptions or adequately defined criteria. The teams more often identified evidence beyond written documentation than in the past, including observation and staff interview, but it still was seldom specified what the observation or staff interview should reveal. Sometimes this appeared to be self-evident, but in many cases it was not. This is important because the Post-Move Monitor cannot be expected to have expertise in every area; he must rely on the expertise of the team to explicitly define what he should observe and what staff should be able to explain about the supports to be provided. <u>LA Continuity of Care Process:</u> The Monitoring Team reviewed documentation for nine individuals who had transitioned to the community in the last six months and found eight of the nine (89%) of the LA Continuity of Care Pre-Move Site Review Instruments was completed within the required timeframe and included the required DADS QRS report as an attachment. The ninth instrument, for Individual #231, indicated the residence had been visited in 2012. It further indicated the home still met the criteria of the LA Continuity of Care Pre-Move Site Review, but there was no documentation provided as to how that conclusion was reached. <u>Pre-Move Site Visit Completed by Facility:</u> The APC was designated as the responsible Facility staff for completion of the Pre-Move Site Visit. A revised Pre-Move Site Review form was to be introduced for use on all such reviews occurring after October 15, 2013. No Pre-Move Site Review visits were conducted during the monitoring visit, so the	

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		Monitoring Team was not able to observe the process but rather relied upon documentation to assess compliance. The Monitoring Team reviewed the Pre-Move Site Review documentation completed for seven individuals who had transitioned in the past six months. The Pre-Move Site Reviews for Individuals # 208 and #252 were not included with the completed CLDPs, although this documentation was considered to be the end of the CLDP. It was therefore not clear if these had been completed as required. The seven remaining Pre-Move Site Reviews appeared to have been completed in a timely manner. Only one of the seven (14%) included substantial documentation regarding the presence of required supports. The APC indicated this lack of documentation may have resulted from an error in saving the final Pre-Move Site Reviews as electronic files, but no other evidence was available to review. Findings from the documentation available for review included the following: • The Pre-Move Site Reviews did not routinely address the due dates or specific plan for post-move supports that would need to be in place between the transition date and the 7-Day visit. • The Pre-Move Site Review did not specifically document if it included a visit to each service provision site. • There was no evidence of testing of staff knowledge of individual's needs for supports, services and protections prior to the move. Each called for staff interviews related to at least some supports, but there was no documentation in any of that suggested staff interviews were in fact completed. • The Pre-Move Site Reviews did not document a due date for implementation of non-essential (post-move) supports that were not yet in place. As a result, it was often not possible to verify some non-essential (post-move) supports were being implemented until well after their due date. The rationale for obtaining a plan from the provider rather than just indicating that a support is not yet due is to avoid such gaps. The Facility should ensure it obtains detailed information from the provider as to the plan for implementation. <u>Conclusion:</u> This provision was found to be not in compliance. The Pre-Move Site Review documents reviewed did not evidence that the process adequately assessed the presence of supports or plans to obtain them. This provision relies heavily on supports and evidence having been adequately identified in the CLDP comprehensive assessments and the Monitoring Team did not find this to be the case, as described under Provisions T1c1 and T1d. To move in the direction of substantial compliance, the Monitoring Team recommends an additional layer of review and scrutiny be given to CLDPs before approval and also to the subsequent PMM over the course of the next six months.	
T1f	Each Facility shall develop and	<u>Quality Assurance Processes to Ensure Development of CLDPs:</u>	Noncompliance

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	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.	QA procedures related to ensuring the development of CLDPs included: • A QA Auditor was assigned to monitor Section T. The process used the State Standardized Tools and Guidelines for Section T- Most Integrated Setting Living Options, CLDP, and PMM. A quarterly report was generated from data collected from observations and document reviews. Record audits were to be completed monthly by the APC and the Program Compliance Monitor. New section T monitoring tools had been drafted by DADS and were currently undergoing review and comment by SSLC staff. • The APC continued to track the provision of the 45-Day assessments by the various disciplines. • The APC had not found it feasible to continue holding a Pre-CLDP meeting held ten days prior to the CLDP meeting to review and reconcile information and recommendations in assessments. This was unfortunate given the findings related to CLDP assessments detailed in Provision T1d above. <u>Quality Assurance Processes to Ensure Implementation of CLDPs:</u> The Pre-Move Site Review conducted by the APC continued to provide an additional layer of scrutiny to ensure that essential supports were in place prior to an individual leaving the Facility. The Monitoring Team commended this practice, as the existing LA pre-move site visit did not focus heavily on ensuring specific supports were in place; however, the process needed to be improved to be fully functional as a mechanism for ensuring quality. A Program Auditor continued to be assigned to accompany the Post-Move Monitor on a sample of PMM visits to monitor the accuracy of the findings. In addition, the Facility continued to implement a process developed as a part of a Corrective Action Plan (CAP) during the previous monitoring period to address issues that had emerged as the result of a failed transition. The process focused on ensuring that providers notify the Facility of issues and concerns on a timely basis. The QA Director also reported a plan to develop a process to monitor a sample of completed transitions. <u>Conclusion:</u> This provision was found to be not in compliance. The quality assurance processes for this Section continued to evolve. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: • Clear performance goals and outcome measures should be defined, along with appropriate methodology for obtaining the data. BSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility. • Given the concerns related to the adequacy of the CLDP as detailed in Provision T1c1 and T1d, the Monitoring Team strongly suggests the Facility undertake a	

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		focused initiative within the Quality Assurance Department and in conjunction with the Department of Admissions/Placements, to improve the quality of all of the processes involved in the CLDP consistent with the findings and recommendations in this report, including the development of outcome indicators and monitoring of CLDP assessments, the CLDP meeting, pre-move in-service training implementation, Pre-Move Site Review and PMM visits.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	<u>Facility Annual Obstacles Report:</u> As reported for the previous site visit, the Facility had provided an updated Annual Report: Obstacles to Community Transition, Brenham State Supported Living Center, Fiscal Year 2012 for review. BSSLC self-identified issues related to the reliability of the obstacle data collection and reporting systems currently in place. The current process clearly did not accurately capture the obstacles. For example, only 26 obstacles to transition in 2012 had been entered into the database from which this report was drawn. The Facility noted it was taking action to ensure that it will remain in compliance with the statewide policy regarding obstacle data collection, reporting and analysis and had developed an action plan to ensure compliance. The Action Plan to improve data integrity regarding obstacles included the following steps: • The APC will provide training for all IDT members twice annually regarding identification of obstacles. • Data collection forms will be revised to capture specific reasons of what individual's reluctance and LAR's reluctance for alternate placement to be entered into a Center database to track and trend the data • The APC will compile the data for trending and analysis on a quarterly basis. The APC will present the Obstacle Trend Reports to QA/01 on a quarterly basis to develop corrective action plans as identified. The Quality Assurance division will monitor the tracking and trending of the obstacles on a quarterly basis and will monitor corrective actions plans implemented. Additional Action Plans were devised to reduce individual and LAR reluctance for alternate placement, to ensure successful placements and reduce the numbers of rescinded referrals. Having accurate and meaningful data as a result of the first Action Plan will allow the Facility to develop more focused Action Plans in the future. <u>DADS Annual Obstacles Report:</u> DADS had issued an Annual Report: Obstacles to Transition Statewide Summary. It	Noncompliance

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		included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • Definitions: Section T.1.b.1 of the Settlement Agreement required that the Facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The State's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." This definition does not seem to adequately capture those issues, barriers or impediments that could prevent an individual from making a choice of a more integrated setting, including a lack of awareness on the part of the individual or LAR or LAR reluctance. These are frequently identified obstacles to individuals' movement to the most integrated setting, and the data in the report reflect that this is so. • Referrals: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared Facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports	

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		certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • Transitions: Surprisingly, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QIDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives; however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).	

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		Conclusion: This provision was found to be not in compliance.	
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 Section III.I.	The Facility did provide an accurate Community Placement Report for the period 4/1/2013-10/9/2013, dated Wednesday, October 09, 2013, that included the following information as further detailed in T1a: • Number and names of individuals placed in the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference Conclusion: This provision was found to be in substantial compliance. The report was made in a timely fashion. As a stand-alone document, it still did not fairly represent the relatively large number of individuals who were not referred due to LAR choice, but the Facility continued to collect this information and provide it to the Monitoring Team for review.	Substantial Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		

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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.	Policies and Procedures related to Post-Move Monitoring: The Facility reported it had begun using a revision of the PMM Checklist on October 1, 2013. Staffing: Staffing devoted to transition included the APC, the Post-Move Monitor, a Transition Specialist funded through the state's Money Follows the Person project and a Children's Specialist. In addition, the Facility had recently hired a Placement Coordinator. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for ten individuals who had moved to the community for both timeliness of the PMM visits and the use of the standardized tool for completing the assessment for the presence of CLDP-prescribed supports. Findings included: • Timeliness of Post-Move Monitoring Visits: The Monitoring Team found that the PMM Checklists were being completed in a timely manner. For 11 of 11 individuals, 21 reviews should have been completed since the previous review. Of the 21 required visits, 21 (100%) were conducted and 21 (100%) were completed on time. • Locations visited: For the 21 PMM visits conducted, 21 (100%) included visits to all sites at which the individual lived and worked/day activity (e.g., day program, employment, public school) • Use of Standard Assessment Tool: Twenty-one (100%) of the PMM visits were documented in the proper format, in line with Appendix C of the Settlement Agreement. The Post-Move Monitor also gathered documentation of the completion of supports and maintained these materials in a file. The Facility began using the statewide revised PMM Checklist on October 1, 2013. Assessment of Presence of Supports Called for in CLDP: The Monitoring Team also reviewed a sample of PMM Checklists for four individuals (Individuals #52, #208, #252, and #490) more extensively to evaluate the process for assessing the presence of supports as well as efforts undertaken by the Facility to ensure implementation of the supports. The PMM Checklists for four of four individuals (100%) indicated that post move monitoring appeared to have been conducted in a thorough manner. The PMM Checklists reviewed appeared to include a verification that each support was in place and being implemented. If there were supports that were not in place as required, the Post-Move Monitor often took actions and maintained a record of emails and phone logs that documented follow-up and loop closure. However, the failure of the IDTs to adequately describe the full set of supports, services and protections needed and the specific evidence required to verify their presence made it	Noncompliance

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		impossible to perform an accurate assessment using only the paperwork. The findings in Provisions T1e and T1d above and in Provision T2b below call into question whether supports are being accurately assessed. Facility's Efforts to Ensure Supports are Implemented: The PMM Checklists reviewed appeared to include a verification that each support was in place and being implemented. If there were supports that were not in place as required, the Post-Move Monitor often took actions and maintained a record of emails and phone logs that documented follow-up and loop closure. However, the findings in Provision T2b below indicated the PMM process was not as vigilant in this regard as necessary. ISPA meetings after each PMM visit: The Post-Move Monitor indicated that the Facility continued to have the respective IDT review each PMM Checklist and that he attended as many of these as possible. The Monitoring Team requested all ISPAs for individuals who had transitioned in the past six months and found 17 of 20 PMM visits had been reviewed by the IDT. Barriers to thorough PMM Review and Improvements Needed in Monitoring: As described in Provisions T1d and T1e, the IDTs still did not yet provide a comprehensive assessment sufficient to prescribe needed supports, nor did they provide adequate direction to the Post-Move Monitor as to the evidence required to accurately ensure the presence of essential and non-essential supports. Conclusion: This provision was found to be not in compliance. The Monitoring Team again commends the Facility for its efforts to implement the PMM process in a rigorous manner; however, continuing deficits remain as described above and in Provision T2b below.	
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	Observation of Post-Move Monitoring Visit: The Facility had indicated it was achieving compliance in the area of PMM. In order to assess the Facility's assertion that it had achieved compliance in this provision, the Monitoring Team accompanied the Post-Move Monitor on the 45-day PMM visit for Individual #208. The CLDP and accompanying assessments were also reviewed. Overall, the Monitoring Team found the Post-Move Monitor was attentive to detail and had excellent rapport with the individual as well as with provider staff. There were, however, issues related to the adequacy of identification of pre or post move supports in the CLDP, which hampered the ability of the Post-Move Monitor to thoroughly assess whether the individual's needs were being addressed. For example, there was a	Noncompliance

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	accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	significant issue related to falls safety that was identified in the Habilitation Therapies Assessment, but not adequately captured in the assessment recommendations or the CLDP pre or post move supports, as further described in Provision T1e. The Post-Move Monitor was not familiar with the recommendation from the orientation and mobility assessment that the individual's risk for falls required a sighted guide on stairs or on uneven surfaces outdoors, rather than use of a mobility cane, which was found not to have been used functionally by the individual in any event. The CLDP did not reference the use of the mobility cane or sighted guide, but it was noted that the Post-Move Monitor monitored for the presence and use of the cane at both the completed 7-Day PMM and the 45-Day. There was no mention of the need for a sighted guide at either setting, although it was noted there had been a number of community outings, including outdoor environments. The Monitoring Team observed some other issues of concern in the PMM process. These included: • When interviewing staff, the Post-Move Monitor had a tendency to ask leading questions that would indicate what the appropriate answer would be. For example, rather than asking staff to describe appropriate supports that were to be provided following meals, the question was framed as to whether the individual needed to remain upright after meals. To test actual staff knowledge, it would be more useful to ask if the individual had GERD precautions and what those specifically were. • The Post-Move Monitor received a copy of the lab work from the provider nurse, who indicated that everything "looked good." However, the paperwork actually indicated abnormal sugar, calcium and kidney function values. The Post-Move Monitor did not observe the discrepancy between the verbal report and the documentation. • The Post-Move Monitor did not independently assess the fire safety and evacuation preparation at the individual's new home. When prompted to do so, it was apparent the staff were not knowledgeable of the plans, including not knowing where the fire extinguisher was kept. <u>Conclusion:</u> This Provision was found to be not in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as areas of focus/priority for the next six months: • Ensure the CLDP provides an accurate and complete description of each individual's needs for services, protections and supports, including the specific evidence to be reviewed by the Post-Move Monitor, as described in T1e. • Additional training should be provided to all staff responsible for Post-Move	

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		Monitoring, focused on overall assessment skills. • The Facility should consider identifying appropriate disciplines or clinicians, particularly familiar clinicians from the respective IDTs, to participate in PMM visits with the Post-Move Monitor, particularly when there are complex health and/or safety support needs. This will assist in ensuring supports are being adequately implemented and positive outcomes are being obtained; it would also provide technical assistance to the Post-Move Monitor in improving overall assessment skills. • Ensure PMM staff are educated on and able to monitor for critical fire and life safety concerns.	
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.		
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	<u>Number and Categories of Alternate Discharges:</u> The Facility reported five alternate discharges had occurred since the last on-site review, all of which involved a transition to another SSLC. <u>Compliance with CMS-required Discharge Planning Procedures:</u> A review was conducted of a sample of three alternate discharges to determine whether or not the Facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: • If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or	Noncompliance

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	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.	discharged for good cause. Based on the information provided, in three out of three records reviewed (100%), good cause was identified in the discharge summaries. • The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): Based on the information provided, for three out of three individuals (100%), it would appear reasonable time was given to prepare. This impression was based on the documentation the transfers were undertaken at the behest of family members, although the discharge packets did not explicitly state when the planning process began. • At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: The final summaries included each of these components, and the information was adequate for one of the three (33%) individuals. • With the consent of the individual, parents (if the client is a minor) or legal guardian, the Facility provides a copy to authorized persons and agencies: Although it would be expected the Facility provided a copy of the discharge summary and related assessments to the receiving Facility, there was no explicit documentation to show that this had occurred. • The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT for none of the three individuals (0%) adequately described the key supports that the individual would need in the new setting. Examples included: o For Individual #402, this section indicated only that the individual would "continue to receive all necessary services and supports" at the receiving SSLC. o Both Individuals #402 and #170 were minors admitted to BSSLC on an interim basis until they were of age to be admitted to another SSLC. Both were admitted at least in part as a result of significant behavioral concerns. The necessary services required in the new environment to were not addressed. For Individual #170, there was a behavioral summary in the Discharge Summary that did provide information about services provided at BSSLC, but the final section on Referrals and/or Necessary Services Required in New Environment (including information to assist the individual in adjusting to the new environment) did not provide any reference to behavioral needs in the new setting. For Individual #402, the only information regarding his behavioral needs was found in the section on reason for discharge/reassignment and this did not provide any information about	

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		needs in the new environment. Conclusion: This provision was found to be not in compliance.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Self-assessment, updated: 09/23/2013 2. BSSLC Action Plans, updated: 09/19/2013 3. Brenham State Supported Living Center Settlement Agreement Monitoring Entrance Presentations, dated Monday, October 7, 2013 4. DADS Policy 019: Guardianship, effective 3/7/2012 5. DADS Policy 057: Self-Advocacy, effective 5/30/12 6. BSSLC Draft Policy: Client Services-Guardianship, un-numbered, dated 12/4/12 7. The most recent prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and a LAR to render such a decision, dated Wednesday, September 11, 2013 8. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 9. Over the six months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 10. Rights Assessment, Form 6614, dated February 2008 11. Rights Assessment, Form 6614, dated September 2011 12. Draft Rights Assessment, Form 6614, dated August 2013 13. Annual ISPs and Completed Rights Assessments for Individuals #76, #106, #263, #288, #314, #445, #471, #483, #521, and #593 14. Guardianship Committee minutes for the past six months 15. Self-Advocacy Minutes for the past six months **People Interviewed:** 1. D'Amber Cooper, Human Rights Officer (HRO) 2. Daniel Dickson, Quality Assurance Director **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #58 and #151 2. Human Rights Committee (Review of Annual Rights Assessments) for Individual #263
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The Monitoring Team reviewed the BSSLC Self-assessment., which indicated the Facility was not yet in compliance with either of the provisions for Section U. The Monitoring Team concurred with this assessment. For Section U, in conducting its self-assessment, the Facility reported it was not using monitoring/auditing tools at this time, and QA/QI processes for this Section were not in place at this time. The Facility reported it was examining what such a monitoring tool would need to include. The Monitoring Team encourages the Facility to first define very specifically those measurable outcomes it believes to be needed to achieve substantial compliance, as well as to meet its own desired expectations. These outcomes will provide a

	sound basis for choosing indicators that will provide useful data for improvement. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Action Steps included development of policy, staff training and identification of supports to assist individuals to make decisions. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. Sections of the Self-Assessment did not reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could tie the Self-Assessment and Action Plans together. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved.
	Summary of Monitor's Assessment: This Section was not yet in compliance. A summary of noted progress included the Facility's continued development of its commendable capacity to provide advocates for individuals as an alternative to guardianship, with some 34 individuals currently having an advocate assigned. A new HRO had been recently hired and was developing strategies for further implementation of the requirements for this section. Specific findings for each provision are as follows: **Provision U1:** This provision was found to be not yet in compliance. There was no statewide or local policy that addressed either a standardized process, methodology, or tool IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making, nor was there any evidence that IDTs were yet making any concerted effort to address capacity for decision-making or strategies to enhance these capacities. It was reported DADS hoped to promulgate an assessment process in the near future. The Facility did maintain a prioritized list of individuals lacking an LAR, which was updated on an ongoing basis based on referrals from the IDTs, but not all individuals on the list had yet been assigned a priority. **Provision U2:** This provision was found to be not in compliance. It was reported four guardians had been obtained during the past six months, with one additional pending receipt of the paperwork, and 34 individuals had advocates assigned through a robust Advocacy program. The Facility's Guardianship Committee continued to meet as called for in the DADS Policy. The Facility continued to need to ensure it has an appropriate methodology in place to determine the actual need for guardianship.

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U1	Commencing within six months of the Effective Date hereof and with	<u>Policies And Procedures Related To Functional Capacity To Give Consent And/Nor Need For LAR:</u>	Noncompliance

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	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.	No new DADS policies had been issued related to this provision. DADS Policy 019: Guardianship, effective 3/7/2012, addressed the development and maintenance of a prioritized guardianship list as required. The Monitoring Team has expressed concern in previous reports that the policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized process, methodology, or tools IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. The Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance needed to be provided as to how, and how often, a need for guardianship should be periodically reviewed. The HRO confirmed that a statewide policy was pending on this topic in the near future that would prescribe the tools and or processes to be used by IDTs to assess decisional capacity. A draft of a revised Rights Assessment, IRA Form 6614, dated August 2013, had been recently circulated to the HROs for comment. This document was reviewed by the Monitoring Team and found it did not appear to vary significantly from Form 6614, dated September 2011, a version that required IDTs to answer a series of questions in each category of informed consent. The newest version added an instruction that the IDT was to provide "sufficient documentation" to answer the informed consent questions. At the time of the monitoring visit, there was no additional guidance as to what documentation would be considered sufficient or how it should be gathered. The draft local policy on Guardianship remained unchanged since the previous monitoring visit and had not yet been approved for implementation. The HRO was new to the Facility, having been in the position for approximately one month. She was in the process of developing localized policies that would accurately represent the procedures in place at BSSLC. <u>Maintenance of Prioritized List:</u> The Facility maintained a list of individuals who did not have current guardians, organized by area of residence. This list was entitled Prioritized List and included certain other information regarding rights restrictions for each individual and provided running documentation as to activities related to guardianship and advocacy status. The Monitoring Team reviewed the provided Prioritized List for timeliness of updates to the list and the prioritization process: • <u>Timeliness of Updating Process:</u> The SA requires the prioritized list to be updated semiannually. The HRO reported the list was updated each Monday. The Monitoring Team reviewed a list dated Wednesday, September 11, 2013. It	

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		included 40 individuals. The Monitoring Team notes these data vary with some frequency as regular updates are made and admissions, discharges and guardianship status changes occur. Another undated document, provided in the document request, titled Individuals without Guardian and or Advocate, listed 44 individuals without a guardian, and the HRO reported during interview on-site that this number stood at 36. • Prioritization Criteria: The Facility continued to use the same prioritization criteria as previously reported. The September 11, 2013 list provided indicated the priority level for some, but not all, individuals was assigned. The list provided for review indicated 16 of the 40 individuals on the list (40%) individuals were not yet assigned a priority. Assessment of Functional Capacity to Render a Decision: The Facility did not yet routinely use standardized or valid processes, methodology, or instruments to assess functional capacity, so the decision to place someone on the prioritized list continued to be without a sound basis for the most part. During the past six months, the IDTs continued to address the ability of an individual to provide informed consent using an annual Rights Assessment form dated February 2008, but this process was not predicated on any objective criteria. The form indicated the determination should be based on assessments and the annual review process, but there were no instructions or accompanying guidance as to which assessments were to be used, what criteria should be addressed in the completion of the assessments, or what portions of the assessments would pertain to decision-making capacity. Similarly, there was no guidance as to what the annual review process should entail in order to support these determinations. The Facility indicated it did not have a standardized process, methodology, and/or tool to use in this process. It also noted it no longer asserted it relied, as previously reported, on the Functional Skills Assessment (FSA) to provide any rationale for IDT decisions in the area of capacity to provide informed consent The Monitoring Team reviewed a sample of ten recently completed ISPs, including the Rights Assessments. The findings of the review of the Rights Assessments continued to suggest the IDTs did not yet comprehend their obligation to assist individuals to continue, on an ongoing basis, to enhance their capacity to participate in decision-making. Overall, there was no substantive attention paid to this process, as indicated by the following findings: • For none of the ten reviewed (0%), did the IDT conclude the individual was able to give, or participate in giving, informed consent in any of the six areas listed. • There was typically no specific basis offered for this determination in the way of an individualized assessment of the individual's decision-making capacity. In two of ten (20%) instances the IDT made some attempt to provide a rationale	

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		for the determinations, but this was not based on any valid formal assessment process. Both of these Rights Assessments indicated the determinations were based on the Functional Skills Assessment, which the Facility stated it no longer used as a basis, and on either personal observation or the annual review process. No specific observational or review criteria were defined or addressed that would support these statements. • IDTs should provide in the Rights Assessment specific expectations for how staff will be expected to support individuals' participation in decision-making, consistent with a thoughtful assessment of the input each is able to provide. In none of the ten Rights Assessments (0%) reviewed did the IDT document any strategies to improve the individuals' skills or abilities to participate in decision-making. • This finding was borne out in observations made by the Monitoring Team of the ISP meetings held during the site visit. For none of two individuals (0%) did the IDT undertake any substantive discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent. The Monitoring Team also observed the review of the Rights Assessments for Individual #263 at a weekly meeting of the facility's Human Rights Committee (HRC) and found the HRC members did not address the informed consent restrictions in a substantive manner. The HRC should address the informed consent restrictions in the same manner as other restrictions, including requiring rationale for any restrictions and the plans to reduce the need for them. <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility did maintain a list of individuals it deemed to be in need of a guardian that was updated regularly, but the determination of need was not predicated on any formal or standardized process or tool. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility will need to prescribe an assessment process, methodology, and/or tool rooted in objective evidence-based principles of decisional capacity, and further, require the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those	<u>Policies And Procedures Related To Obtaining Lars For Individuals In Need:</u> DADS Policy 019: Guardianship, effective 3/7/2012, provided guidance and protocol as to obtaining LARs for individuals who may need one. The Facility reported there had been no changes to the statewide policy. BSSLC had drafted a localized version of DADS	Noncompliance

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	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.	Policy 019, dated 12/4/12, which was not yet considered final pending statewide revisions related to the functional capacity assessment. No changes had been made to Policy 057: Self-Advocacy, effective 05/30/12. As noted above in Provision U1, the newly hired HRO was in the process of developing localized policies that would accurately represent the procedures in place at BSSLC. Facility Efforts to Obtain LARs: The Facility reported four new LARs had been obtained during past six months for individuals living at BSSLC. Another guardianship hearing was held in September 2013, but the legal paperwork had not yet been received. Guardianship Committee: The HRO served as the BSSLC Guardianship Coordinator as required by the statewide policy. The Facility had established a Guardianship Committee. Meetings were being held once each month. Membership appeared to be consistent with statewide policy requirements. The statewide policy also called for the HRO to maintain data, including a list of individuals without an LAR; names and priority levels of individuals referred to the Guardianship Committee; status of the referrals; and dates guardianships were secured. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. These data were reflected in the ongoing minutes, providing follow-up information from one meeting to the next through resolution. State Policy also calls for the Guardianship Coordinator to organize an annual guardianship in-service for individuals, families, staff and other interested parties to discuss guardianship, alternatives to guardianship, the benefits and disadvantages of guardianship, limitations to guardianship, types of guardianship, who can and cannot be a guardian, and other relevant topics. The HRO reported this had not yet been implemented. Advocacy Program: BSSLC continued to have an active Advocacy Program as described in the previous report, although the statewide policy had not yet been issued. This appeared to be a thriving program. As of October 7, 2013, the HRO reported 29 of 36 individuals living at BSSLC without a current guardian had been provided with an assigned Advocate. Advocates were matched with individuals through the Guardianship Committee in what appeared to be a thoughtful process as reflected in the meeting. Recruitment and training of advocates continued to be completed by the Volunteer Services Department, which remained a significant resource for the Facility. This was particularly important because DADS had recently issued a directive to the SSLCs to cease allowing employees	

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		to serve as advocates, regardless of any provisions in place to avoid potential conflicts of interest. This affected five individuals at BSSLC who had state employees as advocates. The HRO reported that these five individuals had been or were to be referred back to the Guardianship Committee for re-consideration for a new Advocate assignment. It was also noted that in at least one instance, the previously assigned Advocate continued to maintain an ongoing "special friend" relationship with the individual, but no longer assisted in decision-making. <u>Self-Advocacy Program</u>: As required by Policy 057, the HRO was responsible for providing support for the Self-Advocacy Committee. One Adult Self-Advocacy meeting had been held since the last monitoring visit. The Facility also had a separate Self-Advocacy group for the children residing at BSSLC; two meetings of this group had been held since the previous monitoring visit. The Monitoring Team reviewed the minutes of the Self-Advocacy meetings for both children and adults, but these provided little information other than a brief agenda. It was noted that the Adult Self-Advocacy Committee did not currently have officers and that facilitating the election of officers was to be one of the first priorities of the new HRO. The Monitoring Team observed a meeting of the adult group, the first such meeting with the new HRO, who provided facilitation. The Assistant Director for Administration was also an active participant. Most individuals who attended were accompanied by staff who supported them and helped them participate. The meeting seemed to be organizational in nature, with discussion about officers and elections. Following the meeting, the Human Rights Officer stated that the adolescent group was proposing recommendations for activities and other facility practices. The Monitoring Team encourages the Facility to continue its focus on re-invigorating the self-advocacy program at BSSLC. DADS and the Facility should also consider how to implement a broader vision of self-advocacy that may be incorporated into the everyday lives and program of active treatment for of individuals. For example, regular self-governance meetings could be implemented at all homes, structured to meet the developmental needs of the individuals living there. Classes might be offered to teach individuals meeting participation and leadership skills, which could also be designed to support meaningful involvement in ISP meetings. Statewide policy requires the Self-Advocacy Coordinator to conduct an annual self-advocacy in-service for residents of the State Center, their LARs/family members, and State Center staff, with the involvement of the Self Advocacy Group. When implemented, this would be an opportunity to disseminate such a broader vision.	

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		Conclusion: This Provision was found to be not yet in compliance. The Facility continued to make progress in its efforts to obtain appropriate decision-making assistance for individuals, but did not have an appropriate methodology in place to determine the actual need for guardianship as the foundation for seeking such assistance, as described in Provision U1 above. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility need to prescribe an assessment process, methodology, and/or tool rooted in objective evidence-based principles of decisional capacity and, further ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully. The Guardianship Committee should be provided with training regarding the assessment process as well to facilitate their appropriate review of referrals made as a result.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment 9/23/13 2. BSSLC Action Plans 9/19/13 3. Presentation Book for Section V 4. Provision Action Information for Section V 5. List of new and revised policies implemented since the last compliance visit 6. DADS Policies and Procedures a. DADS Policy 015.1 Dental Services 8/15/13 b. DADS Policy 003.2-Quality Assurance 5/22/13 c. DADS Policy and Procedures 007.3 Psychiatry Services 05/01/2013 d. DADS Policy 009.2 Medical Services 5/15/13 e. DADS Policy 010.3 Nursing Services 6/17/13 f. DADS Policy 017 Habilitation, Training, Education, and Skill Acquisition 8/1/13 7. BSSLC Policies and Procedures a. BSSLC Policy A.5 Training Requirements 6/5/13 b. BSSLC Policy D.5 Prohibition Against Retaliatory Action 5/15/13 c. BSSLC Policy D.7 Placing & Monitoring Alleged Perpetrators on NCD 8/3/13 d. BSSLC Policy DD.2 Injury Reporting Semi-Annual Under Reporting Audits (8/24/13) e. BSSLC Policy E.1 Quality Assurance Process 6/1/13 f. BSSLC Policy E.2 Quality Assurance Quality Improvement Council 4/21/13 g. BSSLC Policy F.1 Individuals Support Plan (ISP) Policy 10/26/12 and draft revisions h. BSSLC Policy M.3 Staff Responsibility in a Hospital Setting 8/3/13 i. BSSLC Policy N.9 Pharmacy Services and Safe Medication Practices, Quarterly Drug Regimen Reviews 7/1/13 j. BSSLC Policy N.12 Medication Variances 6/5/13 k. BSSLC Policy N.13 Destruction of PHI Material 6/5/13 l. BSSLC Policy DD.2 Injury Reporting—Semi Annual Under Reporting Audits 7/24/13 m. BSSLC Policy P.1 Habilitation Therapy Services 8/7/13 n. BSSLC Policy P.2 PNM Plans 8/7/13 o. BSSLC Policy R.1 Communication Services 8/7/13 p. BSSLC Policy S.2 Developing and Tracking Skill Acquisition Programs (approved 10/2/13 for implementation 11/2/13) q. BSSLC Pharmacy Services and Safe Medication Practices; Adverse Drug Reaction policy, revised 10/10/2013 (unnumbered) r. Policies approved 10/2/13, per report of the Director of Quality Assurance, but without approval or planned implementation date, and Policy & Procedure Approval/Review Forms: i. BSSLC Policy S.3 Training and Monitoring Skill acquisition Programs ii. BSSLC Policy T.1 Admissions/Transfers/Re-assignments

	iii. BSSLC Policy L Medical Care iv. BSSLC Policy K.1 Behavioral Services Department v. BSSLC Policy D.7 Placing & Monitoring Alleged Perpetrators on Non Direct Care (NDC) Status vi. BSSLC Policy C.2 Restraint for Behavioral Crisis vii. BSSLC Policy C.3 Medical Dental Restraint viii. BSSLC Policy W Professional Oversight in Residential and Program Areas ix. Staff Supervision Levels (no policy number) 8. Policy Manual Table of Contents 9. Policy-Procedure Review Committee Meeting Minutes 10/9/13 10. Active Record Order & Maintenance Guidelines 2-Chart Index (rev. 4/20/13) 11. Guidelines for Scoring the Internal Audit 10/19/12 and Internal Audit Notes July 2013 12. Settlement Agreement Cross-Referenced with ICF-MR Standards, Section V (referred to in this report as Section V monitoring tool) 13. Active records clerk description of responsibilities 14. Power Point presentation for New Employee Orientation training on recordkeeping 15. URC presentation notes for New Employee Orientation training on recordkeeping 16. Training materials for active records clerk training, including attendance sheets 17. List of record audits to be completed in October 2013 18. Guidelines for Scoring the Internal QA Audit 19. Internal Audit Notes (July 2013) 20. Settlement Agreement Cross-Referenced with ICF-MR Standards Section V: Recordkeeping and General Plan Implementation Guidelines 21. Record Audits, including emails regarding corrective actions for 16 audits conducted July, August, and September 2013 for Individuals #68, #95, #123, #184, #217, #239, #309, #349, #363, #377 #415, #474, #517, #539, #546, and #574 22. Document Tracking database for internal record audits—July, August, & September 2013 23. Section V Quarterly Quality Assurance Report to QA/QI Council 9/25/13 24. Active Record, Individual Notebook, and Master Record for Individuals #532 and #533 25. Active Record for Individual #93 26. Master Record for Individuals #26, #93, #261, #398, #417, and #504 27. Chard Audit Tool for Individual #264 28. Response to request for an ISP assessments tracking log 29. Response to request for a description of how the Facility monitors to determine whether assessments are completed and filed 30. Interview Tools for use of the Record, Problematic Tracking System for Interview Tool, and Summaries of Interview Tool for September 2013 for Individual #546 **People Interviewed:** 31. Group interview of Joyce Carnagey and Olivia Najera, Unified Records Coordinators, Monica Perez, CARE/CWS, and Daniel Dickson, Director of Quality Assurance (QA) 32. Daniel Dickson, Director of QA 33. Group Interview of Pam Boehnemann, QIDP Coordinator, and QIDPs Kathryn Seifert, Jamie Kucera, and

	Anne Schrengauer **Meeting Attended/Observations:** 34. Annual ISP planning meeting for Individual #58 35. ISP Preparation meeting for Individual #330 36. ISPA post hospitalization meeting for Individual #318 37. Records storage at Fannin A and C, Bowie A, Childress A, Driscoll C, and Cottage E 38. Policy Review Committee
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section V, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ Active Record Audit form ▪ Individual Notebook—Active Record Audit form ▪ Section V Monitoring Tool ▪ V4 Meeting Observations Tracking o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as audits of records using standardized audit tools and guidelines for scoring, the use of a standard set of questions regarding use of records, and observation at meetings for presence of records. o The Self-Assessment identified the sample(s) sizes, except that it was unclear for the first item in Provisions V1 and V3; these reported review of the active records and individual notebooks, showing 100% of records include an Active Record Guideline and Individual Notebook Table of Contents. The Self-Assessment did not state whether these were 100% of the records in a sample, or whether a review was done of records for all individuals. The Self-Assessment did not compare the numbers in the samples with the population from which the sample was drawn, but record audits would be drawn from the whole population of the Facility. For the use of the V.4 Interview Tool as reported in Provision V4, the sample of 10 tools was stated, but the number of clinicians to whom they were sent was not (and, with a 72% completion, there were evidently more than 10 sent). The sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Unified Records Coordinators (URCs)

	○ The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. ○ Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ Used other relevant data sources and/or key indicators/outcome measures, including: ○ Spot checks of corrections to determine completion ○ Number of State policies released since the last assessment, and the number of those that had been operationalized into local procedure. ○ Percent of facility procedures that were updated per local procedure requirements ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: ○ Presented findings consistently based on specific, measurable indicators. However, the Facility provided data on record audit findings as overall percentages; it would be useful to include in the assessment information about specific Appendix D requirements or areas of concentration (such as timeliness of assessments) that need to be addressed in order to establish compliance. ○ Consistently measured the quality as well as presence of items. Although it was not the role of the records audits to evaluate the quality of the documents, they did evaluate the comprehensiveness of the records. ○ All data reported in the Self-assessment were collected by the QA Department. ▪ The Facility rated itself as being in compliance with none of the four provisions of Section V. This was consistent with the Monitoring Team's findings The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Completed, In Process, or Not Started. Some noted as In Process were completed by the time of the compliance visit (such as providing training to the program clerks and training new employees as part of orientation, both of which had begun and will be ongoing). ▪ The Facility data identified areas of need/improvement. Actions addressed areas of need/improvement, such as providing training to new employees and reviewing documentation from a sample of new employees to improve consistency of compliance with requirements of Appendix D, and addressing a need to update policies by implementing a process which identifies when facility procedures are to be implemented and how training on procedures will be completed.. ▪ Although several actions provided steps likely to lead to compliance with the requirements of this Section, the action plans as a whole were not likely to lead to substantial compliance. Given that audits and checks for corrections had been in place for several compliance visits without records being substantially compliant with Appendix D requirements, steps need to be taken to ensure that corrective actions are consistently completed and that staff consistently continue to document accurately in records.
	Summary of Monitor's Assessment: The Facility continued to make progress in most areas of recordkeeping and policy development and

	implementation. The Facility maintained a unified record. A significant change had been made recently in the process for filing documents in the record. Rather than having each discipline file documents, these were no to be given to the record clerk for filing. This was intended as a systemic change to improve presence of current documents and accuracy of order of filing. Numerous new policies had been implemented. Use of the record had improved, although it remained somewhat variable. Provision V1: Records were generally in order, and documents were, for the most part, present and current. Compliance with the requirements of Appendix D had, however, decreased slightly. Records were accessible; aside from the unified record, a computer shared drive permitted ready access to assessments and other documents. Provision V2: Both DADS and BSSLC had developed numerous policies, and the process is ongoing. By policy, all policies are to be reviewed annually; several policies had not been reviewed for an extended time. As policies are developed and approved, the determination is made of who requires training; the determination of the kind of training is assigned to a responsible person who is also responsible for verifying training is done, but there is no standard procedure for tracking who has been trained or still needs to be trained. To move toward compliance, the Monitoring Team recommends the Facility establish a clear set of procedures to ensure training on policies meets the needs for implementation of those policies, and can be tracked to ensure all staff who need training receive it. Provision V3: The audit system did include random audits of five or more records and did have a process to monitor all deficiencies identified in each review to identify corrective actions that need to be taken. Systemic actions to improve compliance had been in place for too short a time to expect improvements to be evident. Although improvement appeared to have occurred in presence of current documents, it was not yet adequate to find that the audit process and systemic actions taken had yet been effective at limiting reoccurrence of errors. Furthermore, the corrective action process for deficiencies identified in audits of individual records did not follow through to correction of all deficiencies nor address those corrections that required action to limit reoccurrence (such as retraining) when the records themselves could not be corrected (for example, for legibility issues). Thus, the audits themselves provide the information needed about the status of records, but the corrective action process needs improvement. Provision V4: Most documents were present and current in the active record, and therefore available for use in decision-making; however, assessments were not consistently completed and posted in time for IDT review prior to the annual ISP planning meeting. Observation of ISP and IDT meetings found that the active record was consistently present. Documentation was done timely, so that it would be available. Staff reported in interview that records were used and gave examples. Information from the record was used at many meetings, but there were instances in which impressions were discussed although information and data were available in the record.

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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.	Policies Governing Recordkeeping Recordkeeping was governed by BSSLC policies V.1 General Record Keeping Practices and V.2 Filing and Thinning of the Unified Record. In addition, policy V.3 Monitoring of the Unified Record provided the requirements and general procedures for auditing records. These policies had not been revised since the last compliance visit, and further information can be found in the report for that visit. The Facility Maintains a Unified Record The Facility maintained a Unified Record for each individual. The Unified Record at BSSLC consisted of an Active Record, Master Record, and an Individual Notebook sometimes called the "All About Me" book. BSSLC had developed a table of contents for an Inactive Record for overflow documents that will be kept at the Facility for two years and then sent to the state's centralized storage; this table of contents mirrors the active record and uses the same tabs, which should improve ease of finding records when needed. At the last visit, the table of contents had been implemented for six individuals; per interview, it had been implemented only for an additional six individuals due to staff vacancies and prioritizing conversion of the Active Record and Individual Notebook tables of contents. When documents are purged from the Active Record, they are to be sent to Central Records to be placed in the Inactive Record (the overflow record) or Master Record as appropriate; the Master Record also contains other documents, such as legal documents including birth certificate and guardianship papers. The Active Record is stored at the home. A checkout system was in place that involved a checkout sheet in each chart of the record; the person checking out the chart and the location it was taken were to be written on the sheet, which was to be put in the place on the chart rack where the specific chart was stored, and the sheet was to be put back into the chart when it was returned. The Individual Notebook accompanies the individual wherever the person goes for supports and services provided by the Facility. Active Records were filed in two or three binders (charts), depending on the amount of documents involved. An Active Record Order & Maintenance Guidelines (AROG) listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every binder. The AROG had been revised since the last compliance visit. The Monitoring Team reviewed 16 audits conducted by the Facility during July, August, and September 2013. Sixteen (100%) were reported as having all three components of the Unified Record. The Monitoring Team audited the records for Individuals #532 and #533; both records (100%) included al three components. Staffing and Responsibility for Filing in the Record	Noncompliance

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		The Facility had staff assigned to oversee the Unified Record. These staff included two URCs and a coordinator for CARE/CWS; these staff report to the Director of Quality Assurance. A significant change had been made recently in the process for filing documents in the record. Rather than having each discipline file documents, these were no to be given to the record clerk for filing. This was intended as a systemic change to improve presence of current documents and accuracy of order of filing. The change was too recent for the effects to be evident in audits of records. The policy had not yet been revised to reflect this change and was do for review in November 2013. <u>Training of Staff on Documentation</u> The Facility provided training through new employee orientation (NEO) to staff who document in the Unified Record. In the past, the Competency Training and Development department (CTD) provided this training; in September 2013, the URCs began providing the training. The Facility provided the curriculum and training guides used. Review of those curricula indicated the training covered all requirements of Appendix D and included exercises that provided opportunities to practice observation and recording. The materials included a competency test that involved documentation from a video in addition to a set of questions; the Facility reported that the URCs check each test, and retests are given to staff who miss more than the criterion level. At the last compliance visit, the Facility reported that required job-specific on the job training included: • Employee writes a progress/observation note according to "SCOTT" Reporting Criteria and Guidelines for Written Records and supervisor checks for competency using Reported Criteria and Guidelines for Written Records Checklist and gives feedback(.) • Employee locates consumer charts and reviews notes as part of determining baseline behaviors(.) • Employee locates consumer reporting forms(.) The URCs reported that a new process has just begun in which they will sample the documentation done following NEO by a sample of five staff. This was to begin within the month following the compliance visit for the trainees who had completed NEO shortly before the compliance visit. The URCs reported that they meet monthly with program clerks. As part of the transition to all filing by program clerks, training sessions were held to go over the Active Record Order & Guidelines (with a competency quiz) and the audit and correction process. <u>Accessibility and Security of Records</u> The Monitoring Team checked the accessibility and security of records for Individuals #26, #93, #261, #398, #417, and #504. Active Records and Individual Notebooks were	

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		accessible; all active records were either in a separate room or on racks with names turned against the wall so they would not be visible to visitor. Audits of active records for seven individuals in six homes found seven (100%) to be accessible, except for the Medical chart for Individual #398, which was not checked out although staff reported it was as the Dental Department. Checks of Individual Notebooks for five individuals found five (100%) to be readily accessible. In addition, availability of the Master Record was checked by observation of records for Individuals #26, #93, #261, #398, #417, and #504; all were readily available. The Monitoring Team reviewed the checkout system for Individuals #93, #112, #398, #504, and #533. For Individual #112, the Program and Medical charts were absent but were checked out per the system described above in this provision. For Individual #398, the Medical chart was not present, and the checkout card was not present; staff stated it was at Dental. Thus, of all observations, two of three charts (67%) for one of two individual (50%) was appropriately checked out. All other charts were present, and the checkout cards were in the charts (100%). <u>Accuracy, Completeness, and Timeliness of Records</u> To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the Monitoring Team reviewed the complete Active Record for Individuals #532 and #533. Individual #533 was selected by computer randomization out of the admissions since the last compliance visit. Individual #532 was selected by computer randomization from among the individuals the Facility had selected randomly for audit in October. The Monitoring Team used the Section V monitoring tool (titled Settlement Agreement Cross Referenced with ICF-MR Standards, Section V) to rate whether the requirements of Appendix D were met. The Monitoring Team referred to the guidelines provided by the Facility for the Individual Notebook and Active Record and the guidelines for the monitoring tool, as well as to Internal Audit Notes of July 2013 that further defined both some specific items and some procedures to be followed in conducting the audit. In addition, the Monitoring Team reviewed data from facility random audits of sixteen individuals' records conducted in July, August, and September 2013 and reported on a tracking database, as described in Provision V3. Completeness of Active Record and Individual Notebook: All three components of the unified record were in place for both individuals. The Monitoring Team used the Facility's Active Record Audit checklist to record whether documents in the Active Record and Individual Notebook were current and in order; this checklist is described in detail in Provision V3. The Monitoring Team used the Section V monitoring tool (titled Settlement Agreement Cross Referenced with ICF-MR Standards, Section V) to rate whether the requirements of Appendix D were met. The Monitoring Team referred to the	

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		guidelines provided by the Facility for the Individual Notebook and Active Record, and the June 2013 internal audit notes, and the guidelines for the monitoring tool. Because many items recorded as N/A were marked that way because they were not required and were not present, including those might overstate the actual accuracy of the record (if some documents actually had been completed but not filed). Therefore, the Monitoring Team calculated percent present and current, as well as percent in order, with and without including the times marked N/A. The table below provides data determined by the Monitoring Team audit.	

Individual	Present/Current		In Order	
	Without N/A	Including N/A	Without N/A	Including N/A
#532				
Active Record	90%	96%	86%	94%
Individual Notebook	100%	100%	92%	96%
#533				
Active Record	81%	91%	78%	90%
Individual Notebook	94%	96%	81%	88%

The last report noted only the percentages including the items rated N/A and only addressed whether they were present and current but not whether they were in order. For whether documents were present and current (including N/A), the percentages for the Active Record at this visit show moderate improvement compared to two of the individuals at the last visit and significant improvement compared to a third individual. The percentages for the Individual Notebook also show improvement. These data show a high level of accuracy for the Active Record for Individual #532 and for the Individual Notebooks for both individuals. The percent of documents in order was high for the Individual Notebook for Individual #532 but needed improvement for both Active Records and for the Individual Notebook for Individual #533.

Data from Facility random audits of 18 records for July, August, and September 2013 documented that at least 90% of applicable documents were present for 14 of 18 (78%) with a range of 71% to 100%. At least 90% of applicable documents were current (including only those that were present) for eight of 18 (44%) with a range of 70% to 98%, but improvement was evident month by month as the percent current was 17% for July, 33% for August, and 83% for September 2013. At least 90% of applicable and present documents were in order for 13 of 18 (72%) with a range 75% to 99%, with improvement again showing, as the percent for July was 50%, for August was 83%, and for September was 83%.

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		In general, the records were neat, and it was usually easy to find documents. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable. The Master Record was reviewed for both records audited by the Monitoring Team. All required documents appeared to be present, and the documents were filed neatly and were easily accessible. Consistency with Appendix D Requirements: Neither record met all requirements of Appendix D. The Monitoring Team completed the Settlement Agreement Cross-referenced with ICF/MR Standards review (the Section V monitoring tool). For Individual #532, the records met 17 of 26 requirements (65%) assessed by the Monitoring Team and found applicable. For Individual #533, the records met 14 of 26 requirements (54%). This was a decrease from the findings of the last compliance visit. The Monitoring Team reviewed the Monitoring Tools completed by the Facility as part of audits in July, August, and September 2013 for Individuals #68, #239, #309, #349, #474, #539, and #546. The range in percent of applicable requirements met was from 67% to 75%. The Monitoring Team also reviewed the Section V Quarterly Report for the QA/QI Council meeting of 9/25/13. This report included graphs of the data for the period 5/1/13-7/31/13. One graph provided the percent of compliance for each requirement on the Monitoring Tool. Compliances ranged from slightly more than 10% for Complete to 100% for several requirements. Another graph combined these requirements into those required for Provisions V1, V3, and V4. Compliance for V1 (having all components of the Unified Record) was 100%; for V3, compliance was approximately 75%; and for V4, compliance was slightly less than 70%. Other examples included: • The Facility provided Integrated Progress Notes (IPNs) for Individual #93; within those, an IPN sheet for Individual #443 was found. The Monitoring Team reviewed the Active Record for Individual #93 at the home and found the IPN for Individual #433 mixed into the IPNs. • As noted in Provision M1, legibility of documentation written by the nursing staff showed improvement, but there should be an ongoing effort made to continue to improve. Documentation carried over the next page in the Integrated Progress Notes was not consistently correctly notated. The times of the entries were occasionally missing on the Integrated Progress Notes.	

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		Conclusion: All this information indicates that the Facility is doing a reasonably good job of ensuring that documents are present and are current, a fair job of ensuring documents are in order, and needs to improve in meeting requirements of Appendix D. Use of Share Drive The Facility had a process and consistent format for filing and accessing specified documents in a Share Drive. Although not considered by the Facility to be part of the Unified Record, the Share drive provided the potential for accessibility to assessments by all members of the IDT. Policy requires IDT members to file their assessments and recommendations on the Share drive 10 working days prior to the ISP annual planning meeting, and requires IDT members to review all assessments and "be prepared for a comprehensive, integrated discussion during the PSP meeting." During an interview, QIDPs were able to access assessments due for an upcoming annual ISP meeting. The last compliance report stated that the process to access the assessments was cumbersome; at this visit, the process was relatively easy, but the QIDP needed to know which assessments were in various folders. The QIDPs reported a plan is in place to provide a "map" of folders to make the share drive easier to navigate and to include all completed assessments in one folder for each individual.	
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.	Facility Process to Develop and Revise Policies A Facility process existed and was followed to develop and revise policies, protocols, and procedures; this process required periodic review and revision as needed. BSSLC Policy A.1 Policy & Procedures Guidelines governed the process. This policy provides steps for identifying the need for policy development or revision, responsibility for drafting policy and getting comments from affected departments and staff, review and approval, entry into the policy manual, notice to departments and staff, and responsibility for training. The policy manual was organized by sections consistent with the sections of the Settlement Agreement. As policies are being developed, they are labeled according to the sections of the manual (for example, the policy that governs Incident Management UIR Committee is labeled D.3). The policy manual table of contents was divided into sections, and the specific policies were to be listed within their sections, along with dates of revision, approval, and implementation. This process made it easy to identify policies relevant to requirements of the Settlement Agreement. A change had been made to the numbering of policies in the manual. DADS policies were now given the letter of the Settlement Agreement section. Localized Facility policies were given the letter and a number. For example, for integrated support plan, state policy is F, local policy is F1, and operationalized policies for specific issues within that policy begin as F2 and are numbered sequentially after that. When new state policy comes out, Facility must respond with a timeframe for operationalizing, training, and	Noncompliance

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		implementing. Policy Committee is also now requiring timelines. The Director of QA reported that all policies need to be reviewed at least annually. So far, it has been up to the disciplines, but the QA Director periodically reviews the dates of policies and provides reminders. The Policy Manual table of contents documented most policies currently in place had been revised in the past year. A number of policies had not been revised. The Monitoring Team did not request information that would verify that these had been reviewed and cannot assess whether that had occurred. <u>Training on Policies</u> The Monitoring Team continues to note that the responsibility for training staff was assigned to department heads. At the last compliance visit, the Monitoring Team observed that the Policy Committee determined training needed for a given policy, who is to develop and provide the training, categories of staff to receive training, how training will be documented and tracked, and timelines. At this compliance visit, the Director of QA informed the Monitoring Team that the staff identified as responsible for the policy determines how the policy is to be trained and keeps the training records; if multiple departments are involved, there may be multiple responsible people. This would make it difficult to ensure all staff required to be trained had, in fact, received the training. As noted in the last compliance report, the Monitoring Team suggests that a centralized process be developed to determine training needed on policies and to track training to ensure all relevant staff receive consistent training. The Director of QA stated that training is required for all staff who are covered under the section of the policy titled "Applies To"; approval of this section would be part of the approval process by the Policy and Procedures Committee. The Monitoring Team observed the Policy and Procedures Committee meeting during this compliance visit. As at the last visit, this committee did actually identify which staff would require training (all IDT members) and assigned the responsibility to determine the training needed and to keep documentation to the Assistant Director for Programs (ADOP). <u>Development and Revision of Policies to Implement Part II of the Settlement Agreement</u> There is evidence that many protocols and procedures required to implement Part II of the Settlement Agreement have been revised as needed; however, some essential protocols and procedures remain to be developed and implemented, and others had been approved but either implemented very recently or not yet implemented. DADS policy development, revision, and implementation: DADS had continued developing and revising policies. New and revised policies since the last compliance visit included the following:	

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		• DADS Policy 015.1 Dental Services 8/15/13 • DADS Policy 003.2-Quality Assurance 5/22/13 • DADS Policy and Procedures 007.3 Psychiatry Services 05/01/2013 • DADS Policy 009.2 Medical Services 5/15/13 • DADS Policy 010.3 Nursing Services 6/17/13 • DADS Policy 017 Habilitation, Training, Education, and Skill Acquisition 8/1/13 • Numerous DADS Nursing Procedures and Protocols, as reported in Section M BSSLC Policies and Procedures: New and revised policies since the last compliance visit included the following: • BSSLC Policy A.5 Training Requirements 6/5/13 • BSSLC Policy D.5 Prohibition Against Retaliatory Action 5/15/13 • BSSLC Policy D.7Placing & Monitoring Alleged Perpetrators on NCD 8/3/13 • BSSLC Policy E.1 Quality Assurance Process 6/1/13 • BSSLC Policy E.2 Quality Assurance Quality Improvement Council 4/21/13 • BSSLC Policy M.3 Staff Responsibility in a Hospital Setting 8/3/13 • BSSLC Policy N.9 Pharmacy Services and Safe Medication Practices, Quarterly Drug Regimen Reviews 7/1/13 • BSSLC Policy N.12 Medication Variances 6/5/13 • BSSLC Policy N.13 Destruction of PHI Material 6/5/13 • BSSLC Policy DD.2 Injury Reporting—Semi Annual Under Reporting Audits 7/24/13 • BSSLC Policy P.1 Habilitation Therapy Services 8/7/13 • BSSLC Policy P.2 PNM Plans 8/7/13 • BSSLC Policy R.1 Communication Services 8/7/13 • BSSLC Pharmacy Services and Safe Medication Practices; Adverse Drug Reaction policy, revised 10/10/2013 (unnumbered) In addition, a number of policies had been approved on 10/2/13 by the Policy and Procedures Committee but were not yet implemented. These were: • BSSLC Policy S.2 Developing and Tracking Skill Acquisition Programs (approved 10/2/13 for implementation 11/2/13) • BSSLC Policy S.3 Training and Monitoring Skill acquisition Programs • BSSLC Policy T.1 Admissions/Transfers/Re-assignments • BSSLC Policy L Medical Care • BSSLC Policy K.1 Behavioral Services Department • BSSLC Policy D.7 Placing & Monitoring Alleged Perpetrators on Non Direct Care (NDC) Status • BSSLC Policy C.2 Restraint for Behavioral Crisis	

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		• BSSLC Policy C.3 Medical Dental Restraint • BSSLC Policy W Professional Oversight in Residential and Program Areas • Staff Supervision Levels (no policy number) <u>Areas in Which Efforts Are Needed</u> The Monitoring Team identified some areas the Facility should consider for revision to policies: • To move toward compliance, the Monitoring Team recommends the Facility establish a clear set of procedures to ensure training on policies meets the needs for implementation of those policies, and can be tracked to ensure all staff who need training receive it. • The Facility did not have a comprehensive OT/PT policy. Missing from policies/procedures reviewed were elements that include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual. • As reported in Section Q, the Facility needed to develop and implement policies, procedures, guidelines, and practices to gain substantial compliance for Provision Q.2. For example, the Facility had no policy or procedure for dental emergencies.	
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.	<u>Audit Policy and Process</u> The Facility had a process in place to audit records, in which the URCs were each assigned to audit six records per month selected through computer randomization; a random list was generated of four individuals from each of the three living units. No individual will be audited twice within a six-month period; the computer randomization process does not pull those individuals. The Facility labeled the audits done by the URCs as Internal Audits. The URCs audit the Individual Notebook and each chart of the Active Record. For each of the audited records, the URCs used the Active Record Audit tool that identifies whether current documents are in the record and whether they are filed in the correct order and location. The form listed in order (per the AROG table of contents) the documents that were either required to be in the record or were in the record if needed. There was a column to state whether the document was current ("Yes"), absent/not current ("No"), or not required for this individual ("N/A"). There was a column with the same headings to check whether the document was in order. There was also a column for comments, where the URCs could state the reason a "No" was checked or make other comments such	Noncompliance

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		as a need to thin/purge outdated documents. The form grayed out the cells for N/A for documents that required a "Yes" or "No" response. Graying out these cells has the potential to improve interobserver agreement as it clarifies which documents may or may not be N/A and eliminates other cells that should not be used. In the last compliance report, the Monitoring Team had noted two of these that seemed odd—one relating to the Reiss Screen and the other to Suicide Risk Assessment; for both, the audit tool had been revised so these no longer had grayed cells. A document titled Guidelines for Scoring the Internal Audit provided definitions for checking a document as Current and/or In Order. In addition, notes from June 2013 provided additional clarification. The URCs used the Settlement Agreement Cross-referenced with ICF/MR Standards (the Section V monitoring tool) to audit four records per month (two per URC). A form titled Section V: Recordkeeping and General Plan Implementation Guidelines also provided "Guidelines for Scoring Y or N" next to each item on the Section V monitoring tool. Although these provided definitions and guidance, they did not indicate whether there was a limit to the number of errors permitted (for example, how many illegible documents could occur and still be rated "Y"). Due to a vacancy and staff absence, only six audits were completed per month in July, August, and September 2013. This still exceeded the requirement of this provision. During those months, there were a total of seven audits using the Section V monitoring tool. <u>Interobserver Agreement/Interrater Reliability</u> The Facility had a process for evaluating interobserver agreement on audit findings for each audited component of the Unified Record. From the six audits assigned to each URC, one individual was selected for audit using the Interview tool and as an inter-rater audit. In a response to a document request for a description of the audit process, the Facility reported that two individuals per month (one per URC) are chosen for an inter-rater audit between the URCs, and two are selected for inter-rater auditing between the URCs and Program Compliance Auditors (PCAs—also noted in some documents as Program Compliance Monitors, PCMs). A spreadsheet lists all the documents in the individual notebook and active record; the ratings of Current and In Order by both raters are entered into the spreadsheet, and the percent agreement is calculated. For this visit, the Facility provided a graph in the quarterly report to the QA/QI Committee about inter-rater agreement. This showed monthly data from August 2012 through February 2013 and again from May through July 2013 (because of staff vacancy, reliability checks were not reported for March and April 2013). The data from June and July were split out so	

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		one bar showed the percent of agreement between the PCA and one URC, and the second bar for the month showed the agreement between the PCA and the second URC. Agreement ranged from 74% to 95%, with all agreement levels since November 2012 exceeding 80%. The graph did not identify whether the data were for "Current," "In Order," or both, or were for the monitoring tool. As noted in the report from the last compliance visit, there had been acceptable agreement for both "Current" and "In Order" for audits during February and March 2013, as well as for the monitoring tool conducted in February 2013. The Facility should make sure graphs have labels that clearly identify what data are represented. As a check to determine whether the definitions and guidelines provided adequate information to permit another rater to agree, the Monitoring Team selected one record (for Individual #532) by computer randomization from among those selected by the Facility for an audit in October. No training was provided other than the guidelines and an undated document entitled Internal Audit Notes (July 2013) that was shared by the URCs and appeared to be a set of instructions developed as a result of interobserver agreement audits. The Monitoring Team audited this record on the same day with no opportunities for the charts to be updated or revised. Agreement data reflect documents for which one or both raters marked "Yes" or "No"; to establish a conservative measure, documents for which both raters marked "N/A" were not considered. Agreement on presence of current documents was 88%; agreement on whether documents were in order was 90%. These showed increased agreement compared to the last compliance visit and demonstrated acceptable agreement. For the monitoring tool, agreement was calculated for all items checked by the Monitoring Team (the Monitoring Team could not rate two items—one about whether access to electronic records was protected, and one about the interview tool used to assess whether the records are being used to make decisions). Agreement was 70%. This was a decrease from the agreement level at the last compliance visit, which was in an acceptable range. Based on these reviews, the Monitoring Team concludes that the levels of interobserver agreement on presence of current documents and filing in order were adequate to provide data that may be valid and useful for making decisions about recordkeeping. However, the level of agreement on the monitoring tool was not adequate to provide data on compliance with Appendix D requirements. The Monitoring Team recommends that the Facility collaborate with other SSLCs to establish guidelines and definitions that might increase agreement between auditors. <u>Audit Findings</u> In response to the document request from the Monitoring Team, the Facility provided copies of 10 audits completed in July and August 2013, and six audits complete in September 2013. The Facility also provided a tracking database for internal record	

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		audits for July, August, and September 2013. This database was extremely useful. It listed all the documents for the Individual Notebook and the charts in the Active Record (Program Chart and Medical Chart). For each record audited, it listed the name and home of the individual, the URC who did the audit, and whether each specific document was present, current, and in order (rated as yes, no, or N/A). It calculated the percent present, percent current, and percent in order. It also calculated, for each item, the percent present, current, and in order across all records audited; review of the database showed the percentages were based only on applicable items, an appropriate and conservative way to make these calculations. The Monitoring Team found this useful, and believes it could be extremely useful in identifying areas for which improvement is needed. At the same time, the Monitoring Team suggests the Facility consider modifying this database, on which percentages across audited records are calculated by sheet (which holds up to four audits) rather than by month. This would require hand calculation of monthly percentages for trend analysis. It might be better to do a single calculation by month for each item so the monthly percentages per item are clear and easy to compare across months. The audit forms have only a column for Current (which requires the documents be present and current to be rated "Yes"), whereas the database has a column for Present and a separate column for Current. Therefore, a document rated "No" for Current on the audit could be rated "Yes" for Present but "No" for Current on the database. Comparison of a sample of findings from audits to the findings on the database indicated the database was almost entirely accurate. The sample of items reviewed had only one error. • For Individual #239, the audit showed the Psychoactive Medication/Monograph to be Present and Current, but the database showed it to be N/A. Nevertheless, it might be useful for the audit forms to include a column for Present and a column for Current. That would allow automatic entry of data into the database from the individual audit forms if they are completed on computer and should eliminate error. Regardless of the above recommendations, the Monitoring Team commends the Facility for implementing this database. <u>Corrective Actions</u> The Facility had a process to take corrective actions for specific deficiencies identified in audit of an individual record, to ensure corrective actions were completed, and to track deficiencies to determine trends that require systemic action. The Facility had placed a database on the S: Drive on which the URCs entered the corrections needed. This database included information such as the name of the individual, the auditor, which binder and tab held the item needing correction, a narrative of the finding, a place for responsible staff to report what corrections were made, the date corrected, who made	

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		the corrections, when the URC checked the correction, and whether the URC found that the correction was complete. This provided an excellent tool to spot easily whether corrections had been made or more follow-up was needed. When items needing corrections from all the audits for the month were entered onto the database, the URC sent an email to Residence Directors, unit clerks, QDDPs, and RN Case Managers notifying them that they were ready for review and correction, and providing a week to complete corrections. When the due date was reached, the URCs checked each correction in the records to ensure it was completed. If a correction was not completed or adequate, the URCs followed up by sending contacting the responsible person and requesting correction within a few days. Also, Unit Directors and Department heads had access to review the database at any time so they could identify any uncorrected items. Although this process had the potential to put the responsibility of documenting corrections on the people responsible for making those corrections, in practice, the URCs did the follow up checks on the basis of due date regardless of whether the responsible person documented that a correction had been made. Furthermore, in interview, the URCs stated they do not continue to check for additional completion of corrections. Thus, no individual had responsibility to follow through until the correction was made. To achieve compliance with this provision, the Facility must have a process to ensure corrections are made. The Monitoring Team continues to suggest that responsibility for completing corrections and for ongoing accurate completion should be assigned to the managers or supervisors of the staff who carry out documentation. Because all filing is to be done by the records clerks, this suggestion would mean the QA department would be assigned responsibility for filing, but other departments would be responsible for the legibility, accuracy, and completeness of the documents they are responsible for completing. For items that could not be corrected (such as missing data or lack of signatures, as opposed to thinning a record or putting documents in the correct order), there was not a clear set of rules for how to document correction. For example, there was no process by which re-training of staff would be documented and provided to the URCs, or how the URCs would spot-check for the effectiveness of re-training. The Facility should develop a process to confirm that corrections, such as re-training, that do not result in a change in the record itself, are made. To verify that spot checks accurately identified corrections made and not made, the Monitoring Team selected one record by computer randomization from the audits conducted in July 2013. One URC and Monitoring Team member checked to determine if all documented corrections to the Active Record and Individual Notebook had actually been made. In the Individual Notebook, all corrections identified on the spreadsheet of corrections needed had been made except for thinning an outdated daily schedule. Several items that had been marked as not completed had, since the last spot check, been completed. For the Program and Medical Books of the Active Record, all items that had	

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		been marked completed at the spot check were verified as completed, but many deficiencies remained not corrected. Thus, the spot checks appeared to provide accurate information, but the lack of a process to continue following the corrections until completed resulted in lack of completion, and the continuing incompleteness or inaccurate filing in the record. <u>Additional Audit Process</u> A second audit process continued in place. The Facility had long had a process in which Program Compliance Auditors do monthly chart audits of active records per month. Program Auditors had a number of program review responsibilities, including monitoring active treatment, doing mealtime observations, and competency checks on a rotating schedule of topics. The Chart Audit Tool used by the Program Auditors differed from the one used by the URCs; it covered many of the items on the form used by the URCs as well as additional items related to the appropriateness of content (such as whether Skill Acquisition Programs are identified on the Action Plan and whether Monthly Reviews address all Action Steps). The audits by URCs and by Program Auditors provide differing levels of detail on different requirements for a current and accurate active record; combined, they would provide both very detailed audit and information that could guide decisions on systemic actions to be implemented to improve accuracy and usefulness of records. This additional audit could be quite valuable if the Facility performed a comprehensive monthly analysis of recordkeeping accuracy that included information from both kinds of audits. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u> Findings of audits were included in the Facility's regular QA process for evaluating status and making decisions about corrective and improvement actions. The Facility provided trend data that could be used to review and assess status of the Unified Record. The Quarterly Quality Assurance Report to the QA/QI Council meeting of 9/25/13 contained the following graphs: • Completion percentage for each item on the monitoring tool for 5/1/13-7/31/13 • Completion percentage for Provisions V1, V3, and V4 for 5/1/13-7/31/13 (the percentages for all the items in each of the provisions) • Completion percentages for each month (May, June, and July 2013) • Internal Audit Analysis July 2012-July 2013 by Unit (no label but appeared to be the total percentage of compliance for items on the monitoring tool) • Percent of Corrections Completed From Internal Audits July 2012-July 2013 by Unit • Internal Audit URC/PCM Inter-rater Agreement August 2012-July 2013 • V.4 Interview Tool Summary July 2012-July 2013	

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		In addition, there was a table for the Internal Monitoring Report that listed each individual record audited in May, June, and July 2013, the percent for the Individual Notebook, each chart (Program and Medical), and all three combined. It did not state whether this was the percent current, the percent in order, or a total for both. The table also listed the percentages by Unit. There was a table for corrective actions, which reported there were none. As reported in Provision V1, the graph of specific requirements of Appendix D (as determined from use of the Section V monitoring tool) showed wide variation in compliance. Compliances ranged from slightly more than 10% for Complete to 100% for several requirements. The graph that combined these requirements into those required for Provisions V1, V3, and V4 reflected compliance for V1 (having all components of the Unified Record) was 100%; for V3, compliance was approximately 75%; and for V4, compliance was slightly less than 70%. The graph showing total compliance by month indicated very stable percentages from slightly over 70% to about 78%. The Internal Monitoring Report table showed percent of compliance for individual records ranging widely. However, there were two issues that made this difficult to assess. First, as noted above, the table did not indicate whether these percentages were for percent current, the percent in order, or a total for both. Second, the data in the column titled "% of all 3 ntbks" did not seem to reflect accurate percents for all records. For example, for Individual #269, the percent for the Individual Notebook was 78%, for Active Chart 1 was 55%, and for Active Chart 2 was 81%, but the percent for all three was 28%. The remainder seemed more accurate, but the Monitoring Team could not confirm accuracy. Furthermore, the percents listed on this table did not match the percents reported on the tracking database. Because the Monitoring Team identified this during review of documents following the visit, there was no opportunity to discuss this with the Facility to determine if there was an explanation for this difference and therefore cannot be certain this was truly an inconsistency. Nevertheless, in order for the Facility to make informed decisions, it is essential the information provided be accurate, so the Facility should review to ensure the databases and report tables and graphs match, and to reconcile any differences. Because the graph of Internal Audit Analysis by month for each unit was based on data from the table, the accuracy of the graph directly reflected the accuracy of the table. If the data were accurate, they showed a fairly consistent percent of compliance, with some dropoff in compliance for two units over the period from May 2013 through July 2013. Whether accurate or not, there was no evidence in the Quarterly Report that the accuracy of records in terms of presence and order of the records or in terms of meeting Appendix D requirements had improved as a result of the audit process.	

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		The Facility had taken systemic actions to improve accuracy of filing and compliance with Appendix D requirements: • All filing was now to be done by records clerks, who had been reassigned to be part of the QA Department to improve communication with URCs. Staff who removed documents from records for copying or other action were now expected to return them to the records clerks, who would return them to the records. Per interview with the recordkeeping staff, this process was relatively new; clerks had received training, and notice had been provided to the various disciplines. The process was too recent for its effects to be reflected in audits. • In September 2013, URCs started teaching the recordkeeping and documentation class in new employee orientation. • The new form for skill acquisition programs will have an initial legend with printed name. Conclusion: The audit system did include random audits of five or more records and did have a process to monitor all deficiencies identified in each review to ensure that adequate corrective action is taken. Systemic actions to improve compliance had been in place for too short a time to expect improvements to be evident. As noted in Provision V1, there was improvement in presence of documents in records, as noted both from Monitoring Team audit of two records and from the audits conducted by the Facility; however, the Facility QA data quarterly report did not reflect the same improvement (although it was unclear whether the report data were accurate). Therefore, although improvement appeared to have occurred, it was not yet adequate to find that the audit process and systemic actions taken had yet been effective at limiting reoccurrence of errors. Furthermore, the corrective action process for deficiencies identified in audits of individual records did not follow through to correction of all deficiencies nor address those corrections that required action to limit reoccurrence (such as retraining) when the records themselves could not be corrected (for example, for legibility issues). To achieve substantial compliance, the Monitoring Team recommends the Facility place responsibility for correction of identified deficiencies and for ongoing accurate documentation meeting Appendix D guidelines on the departments responsible for doing the documentation, which can use the audit results to help identify what needs more attention. Furthermore, the audit process should include follow up to ensure all corrections or actions to limit reoccurrence are completed.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely	The Monitors and the parties agreed to a list of actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions are categorized below, with report of their status at BSSLC.	Noncompliance

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	utilize such records in making care, medical treatment and training decisions.	Records are Accessible to Staff, Clinicians, and Others As reported in Provision V1, the Active Records and Individual Notebooks were accessible; all active records were either in a separate room or on racks with names turned against the wall so they would not be visible to visitor. Audits of active records for seven individuals in six homes found seven (100%) to be accessible, except for the Medical chart for Individual #398, which was not checked out although staff reported it was as the Dental Department. Checks of Individual Notebooks for five individuals found five (100%) to be readily accessible. An example was reported in Provision M1 findings in this report. Observation of Individual #61 found The All About Me Book was present in the room. The DSP was able to review and explain the care plans in the All About Me Book. In addition, the Share Drive makes assessments and other documents easily available to clinicians, QDDPs, and management staff. During the course of this compliance visit, records were accessible to the Facility as needed to provide information. Documents are Filed in the Record Timely and Accurately The Section V monitoring tool for record audits checked whether documents in the record were current. Responses to that item on the reviewed monitoring tools showed zero of eight records (0%) was rated as Current. The Monitoring Team audited two records; the Monitoring Team rated one of these (50%) as Current; this was the record audited as a reliability audit with the Facility, and the Facility rated it as not current. For the two records audited by the Monitoring Team, current documents were present in the Individual Notebook for 94% and 100% respectively; current documents were present in the Active Record for 81% and 90%. Furthermore, the tracking system reported percentages of present documents that were current ranging from 70% to 97%, with eight of 18 records (44%) meeting a 90% level (although improvement occurred in September, with five of six showing at least 90% of present documents were current). For assessments to be used in the annual Individual Support Plan (ISP) process, they must be completed and posted timely to permit the entire interdisciplinary team (IDT) to review them. The Facility ISP policy requires that assessments be completed and placed on the shared drive, for the other IDT members to review, at least 10 working days prior to the annual ISP meeting. For a new admission, Facility policy requires that the assessments be completed and posted at least five working days prior to the initial ISP meeting.	

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		In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. There was evidence the IDTs had begun making use of this function, as five of ten (50%) recent ISPs clearly defined the assessments that were to be completed. In response to a request for an ISP assessments tracking log, the Facility responded, "We started tracking assessment timelines in July 2013, with a new database we received from State Office. At this time, we have found some issues with the reports. We are currently in the process of fixing the problem(s) & I should be able to provide you copies at the onsite visit." When asked during the visit for updated materials, the Facility indicated there were none yet. In response to request for a description of how the Facility monitors to determine whether assessments are completed and filed, the Facility responded "No evidence." During the compliance visit, a consultant from DADS reported the Facility plans to implement a database developed at another SSLC. The database will need to track and report completion based on the assessments identified in the ISP Preparation meeting as required for the annual ISP planning meeting. The Monitoring Team requested the assessments available on the shared drive for Individual #140, whose ISP annual meeting was scheduled ten working days following the date of the request (so that assessments were due by end of the day the request was made). The individual's QIDP opened a folder that contained the assessments. IDT members responsible for specific assessments can link to the folder to post them. The QIDP reported she generally checks those the workday following the day they are due or earlier. The Facility provided a form titled Assessments/Reports Needed for the Annual ISP Meeting. Sixteen assessments were checked as required (OT/PT were both checked, but this is done as a joint assessment); of these, 14 (88%) were current and posted by the due date. The Integrated Risk Rating Form (IRRF), which is a draft used to guide discussion at the ISP annual meeting, was complete except for the behavioral health section. The Preventative Care Flow Sheet was present but did not appear to be up to date. Of the 14 posted assessments, nine had been posted by the time the QIDP opened the folder and the Monitoring Team reviewed it. The assessments list gave dates of completion for the other five, all of which were documented as completed earlier than the day posted, so it appeared that assessments were completed earlier but not posted until the last day. There was no way for the Monitoring Team to know whether these would have been posted had there not been a request to check them. Assessments should be posted when completed. The Facility had not developed systemic actions to improve timeliness of assessments, other than actions by specific disciplines.	

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		Assessments for the ISP were still not routinely completed on a timely basis, as evidenced by the Facility's own self-assessment and by other findings of the Monitoring Team, but there was improvement noted. • In its Self-Assessment, the Facility reported its monitoring data for the period between April1, 2013 and July 31, 2013 indicated comprehensive assessments were completed on a routine basis and when there has been a change in status 19.7% of the time. • In a sample of ten recent ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. • As reported in Provision F1c for a sample of recently completed ISPs, the rate of timeliness was 72%. It was not possible to ascertain assessments that might be missing altogether for five of the individuals, as the ISP Preparation meeting documentation did not clearly prescribe the required assessments; therefore the timeliness compliance rate provided above is based on whether the assessments available in each packet were completed within the required number (either five or ten) of working days before the ISP meeting was held. The Monitoring Team assessed timely completion of assessments in other ways. • Audits of two active records: o For Individual #532, eight of 11 assessments or updates listed on the Active Record Audit form and applicable to the individual (73%) were present and timely according to the assessment dates. o For Individual #533, who had been admitted since the last compliance visit, of 11 applicable assessments, four (36%) were completed at least five days prior to the initial ISP meeting, and six (55%) were completed within 30 days following admission. • As reported in Provision R1, for 11 of 11 individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. Eight of eight individuals in Samples R.1 and R.2 (100%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. The Facility could not provide information on timeliness of assessments. Information gathered by the Monitoring Team indicated that assessments were not yet consistently completed and posted in time for the members of the IDT to consider the information in the assessments when preparing for and participating in the annual ISP planning meeting. <u>Data are documented/recorded timely on data and tracking sheets</u> The Monitoring Team found that documents were generally recorded timely on data and	

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		tracking sheets. No problematic or widespread examples were found of lack of timely documentation, although there were difficulties in accurate completion of some documents, such as trigger sheets. <u>Staff surveyed/interviewed indicate how the unified record is used</u> The Facility had a process to survey staff regarding use of the Unified Record. Each URC picks one individual from the two audits for which both tools (the active record audit and the Section V monitoring tool) were used. The URC sends an email with a copy of the interview questions to each discipline listed on the S Drive Population Report as serving the individual. Each discipline is to fill out responses to the question and return by email. The URC sends a reminder if there is no response in two weeks. The URC reviews the responses and scores the response by each clinician on each question as either + (apparently indicating the response showed use of the record) or – (apparently indicating the response did not provide evidence of use of the record). The URC summarizes the answer using a tool called the Problematic Tracking System for Interview Tool (Tracking Tool), which includes the name of individual, month and year of audit, number of disciplines polled, number of disciplines reporting, number of positive and negative reports for each question percent of responses to each question that are positive, and feedback regarding the recordkeeping system. It identifies what percent of responses to each question are positive or negative, describes the negatives, and lists recommendations from the URCs to address the negatives. The URC also completes a document called Summaries of Interview Tool that listed each question and summarized, for each, the responses given. The Summaries document included an additional valuable section describing the chart audit in comparison to the responses. The Facility provided the Section V Interview Tool for use of the Record completed for Individual #546, whose record was audited in September 2013. Responses were provided by the QIDP, Speech and Language Pathologist (SLP), physical therapist (PT), occupational therapist (OT), associate psychologist, and physician; according to the Tracking Tool, these were 75% of eight disciplines to which the interview tool was sent. The Monitoring Team reviewed the responses; although there was no opportunity to rate the responses independently (as the ratings were marked on the completed tool), the ratings appeared reasonable. Questions requesting examples of use of the record (Question 1) and of how a report from another discipline helped the clinician plan a treatment or intervention (Question 4) were rated positive for six of six respondents (100%). Question 2 regarding use of the record at meetings was rated positive for four of five respondents (80%--one clinician reported never having attended one of the individual's meetings). For whether documents could be found in the record, four of six (67%) were rated positive; the two that were rated negative did not directly answer the question but instead gave examples of where the clinician found information.	

#	Provision	Assessment of Status	Compliance
		In comparing the chart audit to responses from the Interview Tool, the URC noted, "The QIDP refers to the FSA and assessments in developing meaningful SAPs but there was no FSA or Vocational Assessment filed in the chart. The Physical Therapist and Occupational Therapist refer to (Individual #546's) PNMP but there was no PNMP filed in his Program chart." These comments indicate the URC conducted a thorough analysis and also indicate a reason not to rely solely on the responses to the Interview Tool in assessing use of the records. The Monitoring Team would like to commend the Facility and URC for establishing this process and for a thoughtful review. The Monitoring Team also interviewed three QIDPs and asked these questions; this was a more general interview, as it did not focus on a specific individual. The QIDPs provided examples of using information from the record when making a decision about services and supports for an individual. They stated the record is available at IDT meetings and gave examples of what information would be checked during meetings to ensure information discussed at the meetings is current. They stated they can "usually" find documents in the record. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> The Monitoring Team observed ISP annual planning meetings for Individual #58 and #151, and the ISP preparation meeting for Individual #330. The Active Record was present at the ISP preparation meeting for Individual #330. Nevertheless, in discussion of number of family visits, impressions were given but the record was not checked. At the ISP annual meeting for Individual #58, the Active Record was present. The QIDP periodically scanned the record. The nurse looked up DEXA scores in the record and reported them to the IDT. Target behavior data were on the IRRF draft that was provided to the IDT; during the meeting, the behavior specialist passed out an updated graph. Supporting clinical data was used in the risk rating process for osteoporosis and weight, but not during a discussion of the relationship between falls and challenging behaviors although the IRRF and behavior specialist provided data that could have been referenced. Monitoring Team observations at other IDT meetings indicated the record was present. For example: • At a post-hospitalization, ISPA meeting for Individual #318, the active record was brought to and was periodically referred to during the meeting.	

List of Acronyms

Brenham State Supported Living Center

October 7-11, 2013 Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADOP	Assistant Director of Programs
ACP	Acute Care Plan
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AED	Anti-Epileptic Drug/Automated External Defibrillator
AFO	Ankle Foot Orthotic
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator, Action Plan
APC	Admissions/Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
ART	Administrative Review Team
AS	Action Step(s)
AT	Assistive Technology
BAIP	Behavior Assessment and Intervention Program
BAP	Behavioral Assessment Program
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BMD	Bone Mineral Density
BP	Blood Pressure
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
CBC	Criminal Background Check or Complete Blood Count
CDC	Centers for Disease Control and Prevention
C-Diff	Clostridium Difficile

CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLODR	Community Living Options Discussion Record
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CSO	Campus Supervision Overnight
CTD	Competency Training and Development
CV	Curriculum vitae (resume)
CWS	Client Work Station
DADS	Texas Department of Aging and Disability Services
DCP/DSP	Direct Care Professional/Direct Support Professional
DD	Developmental Disabilities
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DMID	Diagnostic Manual-Intellectual Disability
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRO	Differential Reinforcement of Other Behavior
DRR	Drug Regiment Review
DSHS	Department of State Health Services
DSM/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DSP	Direct Support Professional, Dental Support Plan
DUE	Drug Utilization Evaluation
EC	Environmental Control
EEG	Electroencephalogram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FAST	Functional Assessment Screening Tool
FBA	Functional Behavior Analysis or Functional Behavior Assessment
FFAD	Face-to-Face Assessment/Debriefing
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year

GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HCP	Health Care Plan
HIM	Health Information Management Department at Rio Grande State Center
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMP	Health Maintenance Plan
HOB/HOBE	Head of Bed/Head of Bed Elevation
HRC	Human Rights Committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBW	Ideal Body Weight
IC	Infection Control
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICF/DD	Intermediate Care Facility for Persons with Developmental Disabilities
ICM	Integrated Clinical Meeting
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IMC	Incident Management Committee
IMRT	Incident Management Review Team
IPN	Integrated Progress Note
IRR	Integrated Risk Rating
ISP	Individual Support Plan
IT	Information Technology
i.v./IV	Intravenous
LA	Local Authority (formerly MRA)
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivational Assessment Scale
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MP	Medication Plan
MR	Mental Retardation
MRA/MHMRA	Mental Retardation Authority/Mental Health and Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRP	Medication Response Profile
MRSA	Methicillin-resistant Staphylococcus Aureus
MSP	Medical Support Plan

MTC	Mealtime Coordinator
MVC	Medication Variance Committee
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NDC	Non Direct Care/No Direct Contact
NEO	New Employee Orientation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NP	Nurse Practitioner
O2	Oxygen
O2Sat	Oxygen saturation
OCD	Obsessive Compulsive Disorder
OHCP	Oral Health Care Plan
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OT/OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
PAO	Physical Aggression toward Others
P&P	Policies and Procedures
P&TC	Pharmacy and Therapeutics Committee
PBMC	Psychiatric and Behavior Management Clinic
PBSC	Positive Behavior Support Committee
PBSP	Positive Behavior Support Plan
PBST	Personal Behavior Support Team
PCA	Program Compliance Auditor
PCD	Planned Completion Date
PCP	Primary Care Physician
PDB	Physically Disruptive Behavior
PDD	Pervasive Developmental Disorder
PDP	Personal Development Plan
PFA	Personal Focus Assessment
PFI	Personal Focus Interview
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMOC	Psychiatric Medication Oversight Committee
PMR	Psychiatric Medication Review
PMR-SIB	Protective Mechanical Restraint for Self-Injurious Behavior
PMT	Psychotropic Medication
PMTP	Psychiatric Medication Treatment Plan
PNA	Psychiatric Nursing Assistant

PNM	Physical and Nutritional Management
PNMC/PNMPC	Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth, oral intake
POC	Plan of Correction
POI	Plan of Improvement
PRC	Polypharmacy Review Committee
PRN	Pro Re Nata (as needed)
PRP	Polypharmacy Review Panel
PSA	Prostate Specific Antigen
PSP	Personal Support Plan; Psychiatric Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy/Physical Therapist
PTP	Psychiatric Treatment Plan
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMR	Quarterly Medication Review
QMRP/QDDP	Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional
QPR	Quarterly Psychiatric Review
RAD	Reactive Attachment Disorder
RC	Restraint Checklist
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
ROM	Range of Motion
RRC	Restraint Reduction Committee
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SAN	Settlement Agreement for Nursing
SAP	Skill Acquisition Plan
SFA/SFBA	Structural and Functional Assessment/Structural and Functional Behavior Assessment
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center

SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SQRA	Standard of Quality for Risk Assessment
SSLC	State Supported Living Center
SSO	Staff Service Objective/Specific Service Objective
STAT	Immediate
STD	Sexually Transmitted Disease
TB	Tuberculosis
TD	Tardive Dyskinesia
TIVA	Total Intravenous Anesthesia
TO	Training Objective
UA	Urinalysis
UIR	Unusual Incident Review or Unusual Incident Report
UTI	Urinary Tract Infection
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus
WBC/wbc	White blood cell
x/o	Rule out