United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Review: January 3rd through 11th, 2011

Date of Report: February 25, 2011

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Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

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

Initial reviews conducted between January and May 2010 were considered baseline reviews. Compliance reviews began in July 2010, and are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Corpus Christi State Supported Living Center (SSLC).

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in a section of the report for which another team member had primary responsibility. For this review of CCSSLC, the following Monitoring Team members had primary responsibility for

reviewing the following areas: Antoinette Richardson reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Edwin Mikkelsen reviewed psychiatric care and services; Wayne Zwick reviewed, medical care, dental services, and pharmacy services; Victoria Lund reviewed nursing care, restraint, and safe medication practices; Patrick Heick reviewed psychological care and services, restraint, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed integrated protections, services, treatments and supports, and serving individuals in the most integrated setting, consent and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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

II. **Methodology -** In order to assess the Facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of January 3rd through 7th, 2011, the Monitoring Team visited Corpus Christi State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about Facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans

(PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans (CLDPs), and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

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

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

III. **Organization of Report –** The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

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

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which the Monitoring Panel believes will facilitate understanding and assist the Facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the SA and each of the chapters of the HCG, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility's 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 SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(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:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the Facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for reviews beginning in July 2010; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, 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 SA. The recommendation sections for some provisions include a subsection of additional suggestions for the Facility. These are presented in an effort to assist the Facility in prioritizing activities as the Facility staff work towards achieving substantial compliance with the provision.

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, Individual #45, Individual #101, etc.). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

At the outset, the entire Monitoring Team would like to thank the management team, individuals served, and staff of Corpus Christi State Supported Living Center for their willingness to share information and their time to assist the Monitoring Team in conducting its review. During the January 2011 review, as during the previous reviews, the Corpus Christi team's willingness to provide honest assessments of the status of compliance was appreciated. In addition, when during the course of the review issues were brought to the management team, it responded by addressing them immediately, and developing reasonable plans to correct identified concerns.

As is illustrated throughout this report, CCSSLC had made substantial progress in a number of areas, and in a number of the areas in which there was a need for improvement, the Facility had plans in place to make needed changes. The following provides some brief highlights of some of the areas in which the Facility was doing well and others in which improvements were necessary:

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at Corpus Christi State Supported Living Center:

<u>Restraints</u>

- The monitoring team noted significant activity directed toward reducing the need for restraint and managing how restraints were used. The reestablishment of the Restraint Review Committee under the direction of one psychologist was promising, as were the efforts at training.
- The establishment of a self-assessment process for restraints was noted as a positive development, as was the three-month downward trend in restraint use.

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

CCSSLC had demonstrated significant progress toward compliance in the area of protection from harm. Thirteen of the 22 indicators in this section were found to be in substantial compliance and nine were found to be noncompliant. Highlights of their progress included:

- Policies and procedures had been established to address reporting and investigation of unusual incidents and to require reporting of abuse, neglect, and exploitation.
- Procedures were in place to discourage retaliation against reporters of abuse and actions were being taken to address any allegations of retaliation. However, this was an area that needed continued attention.
- Actions to protect individuals who were involved in unusual incidents or abusive situations were taken quickly. Staff alleged to have been abusive or neglectful were routinely put on temporary work reassignment to remove them from direct contact with individuals served.

- Staff were being trained in reporting abuse and used the information on their identification badges to prompt their actions.
- A flyer had been developed and mailed to the families or legally authorized representatives of all individuals residing at CCSSLC to inform them of their rights to report abuse, neglect and exploitation and the processes and protections for doing so. However, there was not sufficient evidence that individuals were being provided this information at their annual meetings.
- There was evidence of cooperation with DFPS investigations and with investigations by law enforcement and the Office of the Inspector General.

Quality Assurance

- CCSSLC had adopted policies and procedures to guide the development of its quality enhancement program. A Quality Enhancement Plan was in place. The plan set out the audit tools to be used for each section of the Settlement Agreement with corresponding expectations for the samples to be drawn, the persons responsible for auditing, reporting, and analyzing the resulting data, and creating corrective action plans. Although refinements continued to need to be made to the monitoring tools and processes, this reflected substantial progress in this area.
- CCSSLC continued to report trend data and analyses on a quarterly schedule for some key issues, such as restraints, abuse allegations, incidents, and injuries. Information was available to show some specific characteristics of incidents, such as where incidents were occurring, what time of day, and on which living units. Breakdowns of data were available by unit and by residence, making it possible for units and residences to use the data as a tool in analyzing and addressing undesirable trends.
- The Quality Assurance/Quality Improvement Council had been organized to develop, revise, and implement quality assurance procedures. The Performance Implementation Team (PIT) had been reorganized to focus on quality improvements in the units and in service delivery disciplines.

Integrated Protections, Services, Treatments and Supports

- The Facility had adopted the State PSP policy, and developed corresponding Facility policies and procedures.
- All QMRPs had gone through initial training on the new process. Some of the PSP meetings the Monitoring Team observed showed improved facilitation skills, and a person-centered focus.
- Improvement had begun to be seen in the area of identifying preferences of individuals. Incorporation of these preferences into the overall PSP continued to need work.

Integrated Clinical Services

- DADS State Office had created a draft Policy #005 Minimum and Integrated Clinical Services, which laid the groundwork and expectations for integrated clinical services. At the time of the Monitoring Team's review, this was a new policy, received at CCSSLC on 12/7/10 for comments. In the meantime, the Medical Department had made enormous strides in adapting the Health Care Guidelines to CCSSLC, and had provided in-service training to the primary care practitioners (PCPs).

- Despite the need for continuing improvement, the PNMT was an example of a group that had developed into an interdisciplinary team with strong leadership, and was an example of emerging integrated clinical services.

Minimum Common Elements of Clinical Care

- DADS State Office had developed a number of policies relevant to Section H of the Settlement Agreement. At CCSSLC, the Departments were focused on developing sound policies and procedures that were consistent with the State Office policies. Much work had been accomplished in this area of policy completion and training. Implementation was the next phase of development. It will take time to both implement and monitor for compliance. All sub-provisions for Section H remained out of compliance, but the Facility was developing the framework for a successful program.

At-Risk Individuals

- DADS Policy #006: At Risk Individuals, revised 11/2/10, was submitted in draft format. Based on this, an At-Risk Individuals Policy Training webinar was created and provided to CCSSLC staff.
- The State and Facility chose aspiration pneumonia as the first priority condition for risk evaluation and implementation of risk reduction steps, due to the high rate of deaths from aspiration pneumonia. Using criteria the State identified, the Facility had identified approximately 90 individuals identified as at high risk for aspiration.

Psychiatric Care and Services

- The Psychiatry Department had just begun implementing a system that listed an individual's primary symptoms that corresponded to the individual's identified psychiatric diagnosis. Although there continued to be deficiencies in the documentation of the individual psychiatric diagnosis, there had been considerable progress in correcting this deficiency.
- Another positive change had been in the documentation of the communication between the Consulting Neurologist and the Psychiatrist regarding individuals to whom they both provided services. The solution to this problem was to create a system that ensured that the Neurologist reviewed and commented on the most recent Psychiatric Consultation Notes. Each new Neurology Consultation also was discussed and commented on in the following Psychiatry Clinic and documented in the corresponding Notes. This innovation had only recently been implemented and, thus, was not reflected in all of the records reviewed.
- The Psychiatry Department, working in conjunction with the Psychology Department, also had made significant progress with regard to the section of the Settlement Agreement that related to the screening of individuals who did not receive psychotropic medication to ascertain if they had any signs of undetected mental illness. Those individuals who were identified as being in need of a mental health evaluation were then referred for a formal Psychiatric Assessment.

Psychological Care and Services

- Progress was observed in the area of staff development since the last review. Five psychologists completed graduate classes this past fall and advanced toward completing coursework prerequisites for the BCBA exam.

Necessary supervision for application to take the exam, however, had not yet started for any of the psychologists.

- Peer review continued to occur through the Behavior Support Committee (BSC) as well as though the contribution of the contracted BCBA. Concern was noted regarding the consistent attendance of the full membership, as well as with the regularity of scheduled meetings. At the time of the review, supplemental external peer review continued to be pursued.
- A new psychological evaluation update format was introduced and was being utilized. In addition, a significant number of Structural and Functional Behavior Assessments (SFBA) were completed since the previous review. As more and more psychologists become competent in conducting these assessments, the likelihood of developing more effective assessment-linked interventions increases. For now, many psychologists struggled with the learning curve associated with completing these complex assessments accurately.

Medical Care

- Since the last review, many important steps had occurred that were essential in reaching the goal of compliance. The Medical Department now had an improved complement of primary care practitioners (PCPs). This allowed the Medical Director to provide time and expertise to the many administrative duties required of the job.
- The morning medical meeting had been initiated, and represented a first step at standardizing care across the campus, as well as allowing a team approach to be used with the PCPs. With the involvement of many departments, it also should assist in developing the necessary integrated approach to the assessment of individuals, and development and implementation of treatment plans.

Nursing Care

- CCSSLC's Quality Enhancement (QE) Nurse and the Program Compliance Nurse each conducted monitoring activities for different areas using the Facility's nursing tools. Since the last review, the Facility had developed appropriate instructions for each of the nursing monitoring tools, which identified the specific criteria that constituted compliance with each item. Although the Facility reported that inter-rater reliability was established for some of the nursing tools, no written procedure was found outlining the process to ensure the inter-rater reliability process was executed appropriately and consistently.
- In addition, the Facility had developed a draft of the Quality Assurance Committee – Nursing Policy. The purpose of the committee was to establish a systematic approach to monitoring and analyzing information to improve the quality of care and services the Nursing Department provided to the individuals at the Facility. The committee was to meet monthly to review and analyze the data generated from the Health Monitoring Tools or other monitoring systems, and identify trends. The information from the Quality Assurance Committee-Nursing would be reported monthly at the Facility's QA/QI Council. This was an excellent forum for the review and analysis of nursing's monitoring data, and integrated it into the Facility's QA system.

Pharmacy Services and Safe Medication Practices

- The new order review was proceeding well, but the quality of the documentation when communicating with the prescribing practitioner needed improvement.
- The clinical pharmacist completed QDRRs on all individuals residing at CCSSLC each quarter. With regard to review of the recommendations the Pharmacists made, the PCPs were documenting on the QDRR whether there was agreement or not, which was then filed the individuals' records. This area was found to be in compliance with the Settlement Agreement.

Physical and Nutritional Supports

- Significant progress had been made since the last compliance review in reference to the establishment of a Physical and Nutritional Management Team (PNMT). Core PNMT members, as well as alternates had been identified, and included the members the Settlement Agreement required. The initial meeting was held on 7/30/10. At the time of the review, the PNMT had completed assessments for approximately 13 individuals.
- The Habilitation Therapies Department had made progress in the development of a number of policies, protocols, and monitoring forms to support mealtime safety and implementation of PNMPs. These policies, protocols, and monitoring forms provided a strong foundation to support mealtime safety, but no evidence was submitted to document competency-based staff training for participants who were responsible for this mealtime safety initiative.

Physical and Occupational Therapy

- Facility Administration, in collaboration with the Habilitation Therapy Director, had increased the number of physical therapy positions and had approved the recruitment of two additional occupational therapists. However, at the time of the review, the current therapy caseloads for occupational therapists and Physical Therapists continued to present challenges for achieving compliance with Section P of the Settlement Agreement. The Habilitation Therapies Director and staff had begun the process of analyzing the current staffing needs of occupational and Physical Therapists, and the Facility is encouraged to address the findings of the analysis once completed.

Dental Services

- The Facility's Dental Department had made great strides in the past six months. At the time of the most recent review, the Dental Department had a full complement of staff, including two dentists. The oral hygiene index scores, which were a key indicator of individuals' dental health, had improved across the campus. There were only three individuals who had not completed an annual dental assessment, which was a significant improvement since the last review.
- There had been energy and creativity devoted to reducing the missed appointment rates, and although the issue was not resolved, some progress had been made.

- In making observations in the homes, it is evident the oral hygiene was excellent in many cases, due to a Dental Department staff person dedicated to tooth brushing with prescription treatment, as well as teaching the direct support professionals about the oral hygiene needs of the individuals.

Communication

- CCSSLC had made progress in increasing the number SLP positions from two to four full-time SLPs, and one contract SLP at 20 hours per week. Based on interview, the hiring of a fourth SLP will enable the future caseloads of the full-time SLPs to range between 50 and 60 individuals. Reportedly, the newly hired SLP who had been assigned as the Core PNMT member specialized in swallowing and dysphagia. Based on information provided, the Habilitation Therapies Department was conducting an analysis of staffing needs. The Facility is encouraged to address the results of this analysis.

Habilitation, Training, Education, and Skill Acquisition Programs

- Since the Monitoring Team's last visit in July 2010, significant changes in the PSP process had occurred. This included changes within the development, implementation, and monitoring of skill acquisition programs. As anticipated, qualitative changes in the format of skill acquisition programs had occurred, as well as revisions in related responsibilities for their development, training and monitoring. Some of these changes were reflected in the recently revised CCSSLC policy entitled Habilitation, Training, Education, and Skill Acquisition: Implementing and Documenting Active Treatment Programs.
- Continued efforts to improve engagement also had been observed. Engagement was estimated at 76%, which reflected an improvement from the previous visit when it was estimated at 64%. Recent observations also evidenced more examples of formal teaching programs being implemented than previously noted. Summary of system-wide engagement data based on Facility measures, however, was not available for review.
- Opportunities for on-campus and off home day programming and habilitation appeared to be progressing as well. Evidence suggested that PSTs recently had begun to actively problem-solve for some individuals who did not leave their homes.

Most Integrated Setting

- CCSSLC was at the initial stages of implementing the new Community Living Discharge Plan process. Overall, the revised form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. CCSSLC was at the initial stages of implementing these new processes. As a result, many of the documents reviewed for individuals who had transitioned to the community did not reflect these new expectations.
- Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, CCSSLC had begun using the new checklist format, which generally was an improvement over the older version. It added a description of the evidence to be reviewed, and provided space for comments. The Post Move Monitor's comments often provided a thorough

description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). However, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals.

Consent

- Since the last review, the Facility had reviewed the list of individuals who did not have guardians. The Human Rights Officer had developed a prioritized list based on a number of factors, including the level, if any, of family or correspondent involvement in the individual's life, his/her ability to communicate preferences, the health needs of the individual, and the whether or not the individual had rights restrictions in place. Although this appeared to be a thoughtful process, it will be important once the State Office policy is finalized for individuals' teams and the Guardianship Committee to be involved in the prioritization process using similar objective criteria.

Recordkeeping and General Plan Implementation

- Since the State issued the new Table of Contents (TOC) for the active records, CCSSLC staff developed an action plan to address the conversion of the records from the old to the new TOC. The implementation process began in late March 2010, and was completed on 9/1/10. This was a substantial accomplishment in a short time. CCSSLC had Individual Notebooks for individuals prior to the conversion process, and reportedly, all Individual Notebooks were in place. The final phase of the process involved the conversion of individuals' historical files to the Master Record format State Office issued, which the Facility anticipated completing by March 2011.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at Corpus Christi State Supported Living Center:

Restraints

- In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted in regard to the adequacy with which staff described the antecedent- and consequence-based interventions that were utilized prior to the implementation of restraint. It was not clear in all cases reviewed that staff implemented specific strategies from PBSPs in an effort to reduce target behavior and prevent the use of restraint. Concerns also were noted and needed to be addressed with regard to restraint monitors being in place within the 15 minutes, the pharmacist and psychiatrist completing reviews of chemical restraints, a licensed health care professional monitoring and documenting vital signs and the mental status, and nursing staff assessing and appropriately documenting any restraint-related injury.
- Concerns regarding the use of medical restraints without sufficient consent and without acknowledgement within the PSP were noted for some of the individuals reviewed. In addition, although a significant number of

desensitization plans were recently developed and implemented, these plans would be more effective if they were more individualized.
- The inadequacy or inconsistency of PSTs in examining potentially biological/medical, psychosocial, and environmental factors related to restraint as well as in reviewing and potentially revising SFBAs and PBSPs following more than three restraints in any 30-day rolling period was also noted as a concern.

Abuse, Neglect and Incident Management

- To continue its progress toward full compliance with Section D, the Facility will need to fine-tune its processes to make them timely, to provide for documentation of supervisory reviews of investigations and to ensure that investigators are fully trained in the requisite investigatory skills, as well as skills in working with people with developmental disabilities. Two key processes needed additional development: the semi-annual audit of injuries, which was not in place, and the follow-up on recommendations from investigative reports, which were not documented to conclusion.

Quality Assurance

- The next steps for CCSSLC's quality assurance initiatives will include competing the corrective action plan process, creating a data system to collect information generated by the monitoring activities, and developing a set of key criteria to measure progress on service outcomes.
- As the Facility moves forward in developing its self-assessment processes, in addition to the important narrative information included in the Plan of Implementation (POI), the Facility should include data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance. This data would potentially come from a variety of sources, including, for example, the results of monitoring activities, and outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature. This data should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports.

Integrated Protections, Services, Treatments and Supports

- As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning.
- Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen.
- The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State,

working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

Integrated Clinical Services

- Several policies were still in the draft stage, and when implemented, will guide physicians in documenting their review of non-Facility consultants' recommendations. However, requests for documentation to support that this was occurring at the time of the most recent review generated no information.

At-Risk Individuals

- The policy on At-Risk Individuals and the plan related to aspiration pneumonia were well thought out. At the time of the review, they remained to be implemented. The major implementation concern was the intensity of activity required from many departments. The amount of training on treatment of and clinical observation of aspiration, and the voluminous documentation process will be challenging to implement.
- This is an example of an implementation effort that will require an integrated approach, including, but not limited to medical, nursing, habilitation, residential, and day/vocational staff. As is noted in the other sections of this report that address medical, nursing, and habilitation therapies, the competencies of some of these staff were not sufficient to develop and implement treatment plans to address the needs of individuals at high-risk for aspiration and other conditions. The State and Facility will need to address such competency issues in order for the full effects of the new policy to be realized.

Psychiatric Care and Services

- Although the Psychiatry Department at CCSSLC had definitely made progress in meeting some of the terms of the Settlement Agreement since the last review, a fundamental issue remained. The Facility relied on only 12 hours per week of psychiatric consultation time to manage the psychotropic medication for 144 individuals, some of whom had very complex psychiatric presentations. The Facility Medical Director indicated that although the attempts to recruit additional Psychiatrists continued and had produced some responses, no viable candidates had yet been identified.
- An area that continued to require additional attention was documentation to demonstrate empirically that the prescribed psychotropic medications were effective. This is especially relevant for those individuals who were receiving multiple psychotropic medications, as it becomes much more difficult to empirically demonstrate efficacy for individual medications, as the number of medications prescribed for a specific individual increases.
- Another area that will continue to need attention is the identification of the linkage between the psychiatric diagnosis and the identified target behaviors of the prescribed psychotropic medications.
- Finally, an area requiring focused effort is the dual classification of behaviors as both targets of the psychotropic medication, and as being present on a learned basis or as a response to environmental factors.

Psychological Care and Services

- Concern was again noted with regard to the consistency and reliability of data collection. Findings regarding the adequacy of data collection across programs and settings would best be described as mixed. At the time of the current review, inter-observer agreement (IOA) data collection had not yet been initiated.
- Limited progress was noted in the provision of counseling services. Although additional counseling supports had been identified, the nature of these services needed to be outlined within treatment plans, utilizing evidenced-based practices and regular review.
- A new PBSP format had been implemented and a new Behavior Support Committee (BSC) coversheet and spreadsheet were developed to track dates associated with psychological assessments and programming. The new PBSP format appeared likely to improve the quality of behavioral programming and promote improved treatment integrity. Areas for improvement were similar to those identified in the previous reports. Although systems developed to examine the treatment integrity of PBSPs has been implemented, summary data was not currently available for review. Similarly, data to demonstrate adequate competency-based training was also unavailable for review.

Medical Care

- The morning medical meeting had the potential to be more than simply information sharing, but a forum for critical thinking of the cases discussed, especially with focus on preventing recurrence of an acute illness or hospitalization. However, at the time of the Monitoring Team's review, this goal had not been achieved.
- There remained a great need for clinical pathways for many illnesses common to individuals with intellectual disabilities/developmental disabilities (ID/DD). The Monitoring Team's review of individuals with a variety of medical issues showed a consistent trend in a failure to take appropriate action to fully assess the conditions, and consider the variety of options available to treat the individuals.

Nursing Care

- Consistent with the past review findings, significant problems were found regarding the quality of the care regarding acute illnesses, Nursing Assessments and Nursing Care Plans.
- There had been no noticeable improvement in the nursing care and documentation for individuals with health risk issues. In order for the risk system to be effective, the lack of clinical competency in nursing regarding the identification and implementation of clinically appropriate interventions must be addressed. The lack of identification of individuals who are at risk, and require assessment and intense clinical attention is clearly a barrier to building a successful system to ameliorate risk to the extent possible, and address risk factors when they do occur.

Pharmacy Services and Safe Medication Practices

- The system of pharmacy input into use of "stat," or immediately administered, medication was not working, because the pharmacy had not received notifications of the use of such medications. A new system was being developed.

- The Pharmacy Department did not identify a number of irregularities in the DISCUS and MOSES evaluations.
- The pharmacy was not yet monitoring all medication errors and variances across the campus. It was just monitoring those that occurred in the pharmacy.

Physical and Nutritional Supports

- The PNMT reviewed and assessed thirteen individuals who were identified at high risk, but this process did not consistently include all of the necessary components. For example, there was inadequate documentation of risk identification levels based upon physical and nutritional history; analysis or recommendations leading to the development of measurable, functional outcomes for individuals at highest risk to minimize and/or reduce the identified health risk; implementation strategies; documentation of competency-based training for individual strategies; a monitoring schedule for individuals at highest risk; or a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes.
- The current OT and SLP therapy and dietitian caseloads of the Core PNMT members will continue to significantly impact their ability to address adequately their responsibilities as Core PNMT members for individuals at the highest risk levels within the Facility, as well as provide supports to individuals on their respective caseloads.
- Overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or mealtime plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, etc.
- There appeared to be a misunderstanding of the concept of competency-based training for foundational PNS training as well as the provision of person-specific PNMP training. Staff verbalization of a learned skill does not meet the standard of competency-based training.

Physical and Occupational Therapy

- The OT/PT Evaluation template had been updated, but none of the individual records the Monitoring Team reviewed incorporated the revised OT/PT Evaluation template components. Record reviews also showed that individuals had not received an interim update when there were changes in status, such as, but not limited to a diagnosis of aspiration pneumonia, a fracture, falls, diet downgrade, unplanned weight loss, skin breakdown, and/or community transition. Moreover, plans had not been developed that addressed the therapy supports that the therapists, PNMP Coordinators, and/or direct support professionals were providing to individuals.
- Many issues were noted related to the timely provision of wheelchairs and/or wheelchair parts. This had the potential to impact individuals who were at risk, such as individuals at risk due to aspiration pneumonia, and/or skin breakdown. Although orders had been placed, they had not been filled. As the Monitoring Team recommended while on-site, it is essential that this issue be resolved as quickly as possible.

Dental Services

- Challenges remained for the Dental Department including the lack of implementation of desensitization programs. Although plans had been written for many individuals, the quality of the plans was concerning, and

there had been little implementation. Plans also had not been written for individuals who had required physical restraints in order for dental work to be completed. Desensitization plans are a key component to reducing the need for the extraction of multiple teeth due to decay as seen for a number of individuals in the sample reviewed.

- Concerns also were noted with regard to pain management of individuals with emergency dental treatment needs, as well as timely care or follow-up for these individuals.

Communication

- Individual examples provided within Section R illustrate the impact of not having an adequate number of Speech Language Pathologists (SLPs) to address the functional communication needs of the individuals residing at CCSSLC. SLPs were completing evaluations that did not follow the components of the revised SLP Evaluation template, which resulted in individuals not being provided with supports to address their strengths, potentials, and abilities for functional communication. There were not sufficient SLP resources present during the past six months to provide direct and/or indirect speech therapy supports for individuals with an identified need. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations on a formal and/or informal basis within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis.

Habilitation, Training, Education, and Skill Acquisition Programs

- At the time of the current Monitoring visit, summary reports indicated that over 190 skill acquisition plans had been developed using the new format for approximately 12% of the individuals at CCSSLC. Although the sample of reviewed programs demonstrated a significant improvement in quality over previously reviewed skill programs, concerns regarding critical elements with the plans remained. These concerns, identified within some skill acquisition plans, included: 1) the rationale for the specific plan, or in other words, the link between assessment results, PSP, and skill plan was not clear; 2) the adequacy of listed behavioral objectives and prompting hierarchies; 3) insufficient opportunities for teaching trials; 4) specification of discriminative stimuli; 5) instructions to staff regarding error correction; 6) use of differential reinforcement; 7) programming for generalization; and 8) limited diversity/flexibility within teaching methodology, including the use of backward chaining or total task presentation.
- A more comprehensive vocational assessment had been developed and implemented. Concerns remained, however, with the inadequacy of assessment (i.e., objective data, situational assessments, and/or a thorough work history or interest inventory), and lack of individualization with regard to intervention. Concerns regarding the limited community-based options for competitive employment remained.
- Improvement in graphic display of data had continued since the last visit. However, concern about the accuracy and consistency of data collection remained. Similar concerns were noted with regard to adequate staff

knowledge and implementation of skill programs. Until adequate levels of treatment integrity are evidenced, concerns regarding the accurate implementation of programming will remain.

Most Integrated Setting

- At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether or not community placement was appropriate. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.
- The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles.
- The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways.
- The post-move monitoring identified some issues with regard to the provision of services at the community sites. Not all of these items appeared were addressed thoroughly with provider agencies.

Consent

- At the time of the review, the process for assessing individuals' "functional capacity to render a decision" and provide informed consent was still not being completed using a standardized tool. It was anticipated thought that the State Office policy would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area.
- The prioritized list provided to the Monitoring Team included 208 individuals. Based on the current census of 283 individuals at the time of the review, this resulted in an estimated (73%) of the individuals at CCSSLC being in need of guardians. Since the last review, no guardians had been identified for individuals who needed them.

Recordkeeping and General Plan Implementation

- CCSSLC was conducting reviews of at least five records each month. The system for doing this continued to need to be refined to ensure compliance with Appendix D of the Settlement Agreement. The processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends were in the beginning stages of development.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: • **Review of Following Documents**: o CCSSLC Plan of Improvement (POI), dated 9/27/10; o Due Diligence Agency-Specific Requirements: Department of Aging and Disability Services, last updated 7/12/05; o Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation, Form 1020: July 2009 for staff sample; o DADS Employee Alpha Roster, dated 1/03/11; o DADS TX, CCSSLC, Active Employee/Non-employee List, dated 1/6/11 (no non-employees); o DADS TX: Course Due/Delinquent as of 12/31/10; o DADS TX: Individual Training Records for sample C.2 of CCSSLC staff as described below; o Protection From Harm: Restraints Guidelines (draft), revised 12/10; o Appendix B: Bars to Employment, last revised 9/1/10; o Individuals Restrained During Time Period Between 7/1/10 and 11/30/10; o Restraint Reduction Committee minutes for: 8/30/10, 9/29/10, and 10/29/10; o CCSSLC Human Rights Committee Minutes for 7/7/10 through 11/3/10; o Settlement Agreement Cross-Referenced with ICF-MR Standards: C – Protection From Harm – Restraints Guidelines (Draft), revised December 2010; o Settlement Agreement Cross-Referenced with ICF-MR Standards: C – Protection From Harm – Restraints, (monitoring form), revised December 2010; o FY 2010 Restraint Monthly Tracking Log; o Summary of Individuals with Desensitization Plans, including dates of BSC approval, training, and implementation (II.14); o Restraint Checklists, Sedation/Protective Support Consent Form for Medical/Dental Procedures, Desensitization Plans, Personal Support Plans (PSPs), and Monthly PSP Reviews and Monthly PSP Behavioral Services Reviews, as available, for: Individual #10, Individual #26, Individual #68, Individual #74, Individual #144, Individual #168, and Individual #224; o Restraint Checklists, Face-to-Face Assessments, Debriefing and Revision for Crisis Intervention Restraint forms, PSPs, PSP addendums, psychological assessments, Structural and Functional Behavior Assessments (SFBA), Positive Behavior Support Plans (PBSP), Safety Plan for Crisis Intervention (SPCI), and PSP Monthly Reviews (for the last six months or less), as available, for: Individual #275, Individual #246, and Individual #300; o Sample #C.1: The 20% sample was drawn from the Emergency and Programmatic lists, totaling 144 episodes of restraint on the list entitled: "Individuals Restrained During Time Period Between 7/1/10 and 11/30/10." The restraint records for each episode included the restraint checklist form, face-to-face form, the debriefing form, and the individual's

	Safety Plan, if applicable, and for each restraint, the documentation of any and all reviews of this restraint information for: Individual #7 (8/5/10, 8/8/10, 8/14/10, 8/24/10, and 8/26/10), Individual #20 (9/6/10, and 10/2/10), Individual #26 (7/31/10 - two episodes), Individual #92 (11/22/10), Individual #95 (9/22/10), Individual #118 (9/11/10), Individual #158 (7/20/10,), Individual #186 (7/28/10), Individual #191 (7/18/10), Individual #193 (9/20/10), Individual #218 (9/24/10, and 10/6/10), Individual #246 (7/9/10, and 10/15/10), Individual #268 (10/5/10), Individual #275 (10/26/10, and 10/27/10), Individual #297 (8/27/10, 9/16/10, and 9/30/10), Individual #300 (8/11/10), and Individual #325 (11/17/10); Note that for Individual #7 on 8/8/10 two restraints were on one form, and on 8/24/10 two restraints were on one form. o Sample #C.2: The following documentation was obtained for a random sample of 24 staff drawn from the DADS Employee Alpha Roster dated 1/3/11 (the sixth name in each letter of the alphabet): ▪ The date hired and position from the DADS Employee Alpha Roster dated 1/03/11; ▪ DADTX: Individual Training Records for 24 identified staff members to show that each had completed competency-based training on abuse and neglect and on use of restraints; and ▪ Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation, Form 1020: July 2009 for the 24 staff members; o Sample #C.3: The physicians' orders for Individual #38 and Individual #190 for whom medical restraint was ordered (other than for pre-sedation) found in the "Individuals Restrained During Time Period Between 7/1/10 and 11/30/10, and the documentation of the restraint monitoring; o Sample #C.4: For 20% of the 25 individuals restrained with chemical restraint other than pre-sedation on the "Individuals Restrained During Time Period Between 7/1/10 and 11/30/10," including Individual #95 on 9/22/10 at 6:30 p.m., Individual #109 on 10/18/10 at 3:37 p.m., Individual #268 on 10/5/10 at 1:40 p.m., Individual #275 on 10/27/10 at 9:01 a.m., and Individual #246 on 10/7/10 at 12:45 p.m.; o Sample #C.5: Based on documentation provided by the Facility, no restraints had occurred off the grounds of the Facility in the last six months; o Sample #C.6: This was drawn from the "Individuals Restrained During Time Period Between 7/1/10 and 11/30/10" report in which at least 13 individuals were restrained for three or more times in 30 days. The 20% sample included Individual #246 (10/8/10, 10/15/10 - 2 restraints, and 10/18/10), Individual #275 (10/26/10 - 3 restraints, and 10/27/10), Individual #300 (9/22/10 - 3 restraints, and 9/24/10 - two restraints). • **Interviews with**: o Everett Bush, Associate Psychologist V, Chair of the Restraint Reduction Committee; o Robert Cramer, Clinical Psychologist; and o Twenty staff members in various units. • **Observations of**: o Living Units including: Apartments 522A, 522B, 522C, 522D, 515, 516, 511, 514, and 517;

	o Vocational Building 513; and o Atlantic Unit Management Team Meeting, at 10 a.m. on 1/4/11.
	Facility Self-Assessment: The Facility's Plan of Improvement underwent major revisions with the result being an easier-to-understand description of the progress toward compliance with the Settlement Agreement. Based on a review of the Facility's POI with regard to Section C of the Settlement Agreement, the Facility found that it remained out of compliance on six out of the eight indicators. The POI indicated the Facility was in substantial compliance on subsections Section C.1 and C.3. The Monitoring Team did not find the Facility in compliance with either of these, but did with Section C.2. Based on the information included in the POI, it was not clear why the Facility found itself out of compliance with Section C.2. The Facility had established a plan to review restraint documentation and had completed 12 monitoring tools per month in August through November 2010. Based on the information included in the POI, it was difficult to determine what the specific findings these reviews generated. The POI frequently referenced: "12 of 12 monitoring tools completed for…" August through November 2010. However, the results were not shared. In other instances references to a relatively small sample of three restraint records were made. These all indicated "100% compliance" with various indicators. As is illustrated in this report, the Facility's findings were not always consistent with those of the Monitoring Team. This could be due to a number of factors, including the sample size the Facility used, or that the Facility was evaluating the presence or absence of an item as opposed to the quality. For example, the Monitoring Team evaluated both the presence of information on restraint checklists and face-to-face assessments, as well as the quality of that information and its impact on the Facility's ability to adequately review restraints and take steps to prevent the need for their recurrence in the future. As the Facility moves forward in its self-assessment efforts, an adequate sample size should be selected for review, and the Facility should ensure that the quality of efforts as well as the quality of the documentation is evaluated thoroughly. In addition, the POI would be more useful if it included more specific references to the evidence supporting the listed status items. For example, C.5 10/11/10 reported that policy had been revised to reflect a "physician is required to order an alternative monitoring schedule…" It would be helpful to have the specific reference to that policy.
	Summary of Monitor's Assessment: The monitoring team noted significant activity directed toward reducing the need for restraint and managing how restraints were used. The reestablishment of the Restraint Review Committee under the direction of one psychologist was promising, as were the efforts at training. The establishment of a self-assessment process for restraints was noted as a positive development, as was the three-month downward trend in restraint use. In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted in regard to the adequacy with which staff described the antecedent- and consequence-based interventions that were utilized prior to the implementation of restraint. It was not

	clear in all cases reviewed that staff implemented specific strategies from PBSPs in an effort to reduce target behavior and prevent the use of restraint. Concerns also were noted and needed to be addressed with regard to restraint monitors being in place within the 15 minutes, the pharmacist and psychiatrist completing reviews of chemical restraints, a licensed health care professional monitoring and documenting vital signs and the mental status, and nursing staff assessing and appropriately documenting any restraint-related injury. Concerns regarding the use of medical restraints without sufficient consent and without acknowledgement within the PSP were noted for some of the individuals reviewed. In addition, although a significant number of desensitization plans were recently developed and implemented, these plans would be more effective if they were more individualized. The inadequacy or inconsistency of PSTs in examining potentially biological/medical, psychosocial, and environmental factors related to restraint as well as in reviewing and potentially revising SFBAs and PBSPs following more than three restraints in any 30-day rolling period was also noted as a concern.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Based on information the Facility provided in the document entitled Individuals Restrained During Time Period report, between 7/1/10 and 11/30/10: ▪ 162 individuals were the subject of restraints; ▪ 470 restraints occurred. This number included chemical restraint, and pre-treatment sedation; ▪ 38 of these were mechanical restraints; ▪ 114 of these were physical holds; ▪ 318 of these were chemical restraints of which 292 of these were medical/dental pre-treatment sedation; ▪ 46 of 470 restraints were emergency restraints; ▪ 98 of the 470 restraints were programmatic restraints. While restraint use for emergency and programmatic reasons had increased during fiscal year 2010 from 37 uses in the first quarter to 110 by the fourth quarter, the first quarter of FY 2011 showed a marked decrease to 67. Over the course of the first quarter of FY 2011 (September to November 2010), use decreased from 33 in September to 9 in November. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on review of "Individuals Restrained During Time Period Between 7/1/10 and 11/30/10" prone restraint was not identified.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A sample, referred to as Sample #C.1, was selected. This included 17 individuals involved in 30 episodes of restraint, representing 20% of emergency and programmatic restraint records over the five-month period from 7/1/10 to 11/30/10. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample and the dates of restraint are specified in documents reviewed section above. Based on a review of the restraint records for individuals in Sample #C.1 involving 17 individuals and 30 episodes of restraint, zero (0%) showed use of prone restraint. Based on interviews with 20 direct support professionals, all were aware of the prohibition on prone restraint. No one had used prone restraint or seen it used in the last six months. <u>Other Restraint Requirements</u> Based on document review, the Facility policies stated that restraints may only be 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 or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ In 30 of the 30 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Examples of where this was the case included: o Individual #7 attempted to retrieve an item to swallow. o Individual #268 was aggressive, hitting, biting himself, destroying property and attempting to run away. o Individual # 26 attacked staff, banged her head on the floor, and bit her hand. o Individual #297 pulled out her G-tube and was aggressive toward staff who attempted to help her. ▪ For the 30 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 30 (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 27 of the records (96%), 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. An example where this was not the case	

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		included: o On 8/8/10 at 3:40 p.m., Individual #7 was placed in physical restraint (basket hold) followed by chemical restraint due to aggression toward staff and self-injurious behavior. The only alternative to restraint recorded on the checklist was redirection. The Plan of Improvement for CCSSLC dated 9/27/10 regarding Section C.1 indicated that on 10/11/10 the Facility began to require comments on alternative measures on the Restraint Checklist. The checklist for this episode of restraint was completed two months prior. Facility policies did not identify a list of approved restraints. However, Facility policies did specify at C001.C.2 that a Prevention and Management of Aggressive Behavior (PMAB) physical restraint could be used in a behavioral crisis. At C001.C.4, the policy specified that helmets, mittens with ties, and wristlets may only be used in a safety plan or with the approval of a psychologist on duty, the Executive Duty Officer, and the Director of Behavioral Services. ▪ Based on the review of 30 restraints, involving 17 individuals, 28 (93%) were approved restraints. In two cases, two restraints were entered on the same form: o Individual #7 was restrained on 8/10/10 at 3:40 p.m. using horizontal and then chemical restraint. The use of horizontal restraint was expressly forbidden in the individual's Safety Plan Individual #7 appeared on the "Do Not Restrain" list for medical reasons as well. o The same individual was restrained on 8/24/10 at 8:19 p.m. The checklist included horizontal restraint, but then crossed it out, leaving some question as to what happened. An additional sample of three restraint records was reviewed. These restraints involved three individuals who's PBSPs also were reviewed, including Individual #300, Individual #279, and Individual #246. In one of the records (33%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. ▪ The example in which adequate treatment was present included: o The restraint record (dated 9/24/10, 8:19 a.m.) indicated that staff verbally, gesturally, environmentally, and physically redirected Individual #300 following incidents of aggression toward peers and staff. These strategies were clearly outlined in her PBSP. However, staff could have better identified if replacement behaviors were utilized as written. Examples where this was not the case included:	

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		◦ Although the restraint record (dated 10/26/10, 7:50 a.m.) for Individual #279 indicated (by check marks) that staff prompted replacement behaviors and interventions in both the PBSP and safety plan prior to using restraint, actual staff description of their responses brought into question the integrity with which these strategies were implemented. For example, her PBSP indicated that staff should only attempt to problem solve with her once she was calm. It was not apparent from the description that staff "counseled her" after she was calm. Indeed, it sounded as if they were trying to find someone to counsel her when they documented that they "called psych" in an effort to calm her. Both plans clearly indicated that no other communication should occur other than telling her to stop. In addition, the description suggested that staff "… swapped out …," which is not a strategy listed in the PBSP. Given that social attention was identified as a primary function of aggression, switching staff might be counterproductive. In addition, although staff noted that replacement behaviors had been prompted, there was no description of the success of the picture communication strategies, which were related to a replacement behavior to assist her in communicating. Lastly, the preventative strategy of redirecting her to a "private area" as prescribed on her PBSP was not indicated on the restraint checklist (i.e., "changed environment" was one of the few items not checked). ◦ Although the restraint record (dated 10/8/10, 9:20 a.m.) for Individual #246 indicated (by check mark) that verbal prompting and redirection occurred, it was unclear if direct care staff attempted to prompt any replacement or coping skills. That is, these strategies were not endorsed (items were not "checked") and not described within the written statement. Subsequently, it is unknown if staff attempted to implement prescribed replacement behaviors (i.e., communication, problem solve) or other identified strategies (e.g., environmental redirection). It did appear that staff "traded out," which was an approved strategy. The Settlement Agreement requires that restraint not be used in the absence of or as an alternative to treatment. As noted above, staff did not consistently implement Behavior Support Plans to potentially prevent the need for restraint. As a result, a finding of noncompliance has been made.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 30 restraint records involving 17 individuals in Sample #C.1 were reviewed. Of these, 17 records for 10 individuals had Safety Plans that defined the use of restraint: ▪ In 17 restraint episodes where individuals had Safety Plans, 16 (94%) included sufficient documentation to show that the individual was released from restraint	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		according to the criteria set forth in the Safety Plan. However, as noted below with regard to Section C.7, the Safety Plan criteria for release was vague, at times. ▪ In one of the 17 episodes of restraint where an individual had a safety plan, the documentation was not sufficient to show that the individual was released from restraint according to the Safety Plan criteria. Specifically: o Individual #297 was restrained on 8/27/10 at 7:40 p.m. The Restraint Checklist indicated he was quiet and calm two minutes before the restraint was removed, while the criteria for release was when he stopped struggling. As noted below with regard to Section C.7.e, this terminology was vague, and might have contributed to staff not knowing when release was appropriate. ▪ In eight episodes of restraint where individuals did not have Safety Plans or the Safety Plan was not provided in the requested documents, eight (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. ▪ In three episodes of restraint the restraint was chemical and release was not applicable. o In one episode of restraint, Individual #7 on 8/8/10 was restrained in a horizontal hold and then with chemical restraint. It was not clear in the documentation when she was released from the horizontal hold. The POI indicated that a number of steps have been taken to assure that restraint release would be done properly, including modifying the restraint checklist to remove confusing terminology, retraining staff on proper reporting and conducting regular self-monitoring of restraint forms,	
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	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the SA. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. Sample #C.2 included 24 staff members selected at random from a current list of staff. A review of these 24 staff, including their start dates, and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that 20 out of 24 (83%) staff had received training on restraint and its related topics. Of those who were not trained on restraint, one was a clerk, one a food service worker and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	one a custodian, none of whom would reasonably be expected to be involved in restraining an individual. The fourth was a Residential Treatment Technician (RTT) hired on 9/1/04 that did not have a completion date for restraint training. Controlling for staff that worked directly with individuals, this resulted in a compliance rate of 95% (21 out of 22). As noted above with regard to Section C.1 of the SA, 96% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, in order to ensure that the least restrictive method is utilized, individuals' BSPs must be followed, and the preventative steps outlined in BSPs must be implemented. As discussed with regard to Section C.1, a review of three BSPs and related restraint records showed that in only one of the three (33%) had staff implemented the potentially less restrictive alternatives with integrity. This has resulted in a finding of noncompliance.	
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 30 restraint records (Sample #C.1), in 30 (100%) there was evidence documented that restraint was used as a crisis intervention. In review of 10 Behavior Support Plans, in 10 (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 restraint for reasons other than crisis intervention. However, the report entitled Individuals Restrained During Time Period Between 7/1/10 and 11/30/10, included a category called programmatic restraint. According to this document, 98 episodes of programmatic restraint occurred during the time period. Programmatic restraint is not allowed based on the requirements of the Settlement Agreement. According to the State's comments on the Monitoring Team's draft report, the term "programmatic" was used mistakenly, and had been replaced to read: "Crisis Intervention as Specified in the Safety Plan." The State clarified that CCSSLC did not use programmatic restraint. In 23 of 30 restraint records reviewed (77%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list. Examples where this was not the case included: ▪ Individual #7 who was restrained on two occasions, 8/8/10 and 8/24/10, using a basket hold and horizontal restraint in contravention of the medical Do Not Restrain list. ▪ Individual #7 who was restrained on three occasions, 8/5/10, 8/14/10 and 8/26/10, using hand or arm holds. It was not clear from the Do Not Restrain list if individuals named were not to experience any restraints, or only certain types	Noncompliance

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		of restraint. The Behavior Support Plan for this individual indicated that it was only horizontal restraints that should be avoided. To examine the use of sedation during medical or dental appointments, seven incidents of restraint were randomly selected for review from those reported during December 2010. This included the use of restraint across seven individuals, including Individual #10 (on 12/8/10), Individual #26 (on 12/3/10), Individual #68 (on 12/8/10), Individual #74 (on 12/2/10), Individual #144 (on 12/1/10), Individual #168 (on 12/28/10), and Individual #224 (on 12/28/10). Documentation reviewed included Restraint Checklists, Sedation/Protective Support Consent Form for Medical/Dental Procedures, Desensitization Plans, Personal Support Plans (PSPs), and Monthly PSP Reviews, as available: ▪ Upon review of sampled documentation, it appeared that sedation for medical or dental appointments was documented in five (71%) of selected individual's PSPs. Discussion related to sedation use for medical or dental appointments was not evident in the PSPs for Individual #10 or Individual #144. ▪ Documentation for five (71%) of these individuals evidenced appropriate authorization of the use of sedation though the guardian or CCSSLC Superintendent's completion (dated within the last 12 months) of the Sedation/Protective Support Consent Form for Medical/Dental Procedures: o Appropriate consent for the use of sedation for medical or dental procedures, however, was not evident for Individual #10 or Individual #74. Although a consent form was not available for Individual #74, the use of sedation for dental appointments was identified in the PSP. Information regarding sedation for medical/dental appointments was not found in the PSP for Individual #10. In addition, although an Anesthesia Record was provided for the use of chemical sedation (dated 12/8/10) for Individual #10, the relevant Sedation Record was not available for review. ▪ Documentation provided for six (86%) of these seven individuals included current Desensitization Plans implemented to minimize or eliminate the need for restraint. That is, desensitization plans were developed for all sampled individuals, with the exception of Individual #26: o According to the summary of Individuals with Desensitization Plans (document not dated), a desensitization plan had not yet been developed for Individual #26. Information provided on the sampled Restraint Checklist (dated 12/3/10) indicated that no interventions to avoid restraint were attempted due to unanticipated severe dangerous behavior. In addition, the notation "N/A" was documented on the PSP (dated 7/6/10) under the section discussing the need for desensitization plans to minimize or eliminate the need for pre-	

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		treatment sedation. ▪ However, according to the summary spreadsheet provided of Individuals with Desensitization Plans (document not dated), although six (86%) plans were developed for sampled individuals, only two (33%) of those sampled plans appeared to have completed training for staff. More specifically, only the plans for Individual #10 and Individual #74 had dates indicating that training was completed. It was unclear if training was initiated for the remaining plans and not completed, or if the plans were approved (as reflected by the implementation date), but training had not yet been initiated. ▪ Although not requested, Sedation Care Plans also were provided with requested documentation. More specifically, Sedation Care Plans were provided for five (71%) of the individuals sampled. However, of these, two sedation care plans, for Individual #74 and Individual #224, were not completed on the same date as the requested restraint documentation. ▪ The six (100%) available desensitization plans were implemented very recently (in October 2010). Unfortunately, the Monitoring Team did not request monthly data summaries (i.e., PSP Monthly Reviews) for review. Data was provided as requested for Individual #10: o A desensitization plan was developed and implemented for Individual #10 on 10/8/10. Available PSP Monthly Reviews (since implementation), however, did not include any performance data relevant to the desensitization plan. In addition, performance data on this new plan was not reported in the October or November 2010 Behavioral Services PSP Monthly Review (i.e., December not provided). In fact, both reports indicated "N/A" in the section questioning whether or not a "Desensitization Plan in Place?" ▪ Although the majority of individuals sampled (86%) had desensitization plans in place, the plans appeared to be almost identical suggesting little individualization in their development and implementation. The one plan that differed somewhat, although still similar to the others, provided for more specific procedures to be implemented within the natural environment (i.e., dental office. This was included in the Relaxation & Desensitization plan, dated 10/8/10, for Individual #10. In general, all the plans targeted choice-making (of relaxing music or videos) and not necessarily other responses typically associated with relaxation or calm responding. The current homogeneous objectives and strategies reflected a "cookie cutter" approach to treatment and were unlikely to be effective. In addition, they lacked sufficient detail, including clear objectives, individualized reinforcers, and use of differential reinforcement. These plans are described in greater detail in Section S. In order for compliance to be achieved for this section, CCSSLC needs to ensure that	

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		individuals on the Do Not Restrain list are not restrained, and significantly improve the quality and implementation efforts with regard to desensitization plans and/or other strategies to minimize or eliminate the need for the use of restraint.	

C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face-to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Documentation the Facility supplied did not contain the training curricula for training on the application and assessment of restraint. Since the POI indicated that training had taken place, the curricula must be available and was omitted from the document request response. This will be reviewed during an upcoming review.
		
		In addition, a list of the staff at the Facility who had successfully completed the training to allow them to conduct face-to-face assessment of individuals in restraint was not provided.
		
		Based on a review of 30 restraint records (Sample #C.1), a face-to-face assessment was conducted:
		▪ In 30 out of 30 incidents of restraint (100%);
		▪ In 21 out of 30 instances (70%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint.
		    o For Individual #218 on 9/24/10 at 2:12 p.m., the time the monitor arrived was not entered;
		    o For Individual #218 on 10/6/10 at 12:20 p.m., the monitor's time of arrival was documented as "present;"
		    o For Individual #20 on 10/24/10 at 7:38 a.m., the monitor's arrival was not on the form;
		    o For Individual #7 on 8/8/10 at 3:40 p.m., the monitor arrived 10 minutes late;
		    o For Individual #118 on 9/11/10 at 2:07 p.m., the monitor arrived 18 minutes late;
		    o For Individual #7 on 8/5/10 at 6:56 p.m., the monitor arrived 24 minutes late;
		    o For Individual #300 on 8/11/10 at 6:05 a.m., the monitor arrived 30 minutes late;
		    o For Individual #7 on 8/14/10 at 7:35 a.m., the monitor arrived 35 minutes late; and
		    o For Individual #7 on 8/24/10 at 8:19 p.m., the monitor arrived 26 minutes late.
		▪ In 26 instances (87%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included:
		    o For Individual #7 on 8/8/10 at 3:40 p.m., there was no review for the chemical restraint completed by the pharmacist or psychiatrist.
			Noncompliance

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		- For Individual #7 on 8/5/10 at 6:56 p.m., the assessment did not address the use of mittens as part of the restraint. Individual #7 used mittens on a daily basis and was considered part of her safety routine. However, the mittens were listed as a restraint and the result needed to be documented. - In 30 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. - The following concerns related to the documentation on the face-to-face assessment forms were noted: - For Individual #268 on 10/5/10 at 1:40 p.m., the Face-to-Face had an entry for time of release of restraint for a chemical restraint; - For Individual #7 on 8/14/10 at 7:35 a.m., the reviews by the Unit Team and the IMT were not completed. This was found in a number of files, and might mean that the version of the form supplied was not the final version. - Individual #7 on 8/14/10 at 7:35 a.m. was putting inedible objects in her mouth in spite of the precautions in place. Ideas about what else might need to be done in terms of precautions should have been included in the face-to-face analysis at 5.5 on this form. The newer forms have this set of questions at 5.6. Based on a review of 30 restraint records for restraints that occurred at the Facility (Individual #158, Individual #7, Individual #297, Individual #118, Individual #95, Individual #268, Individual #275, Individual #92, Individual #246, Individual #191, Individual #186, Individual #26, Individual #7, Individual #300, Individual #20, Individual #193, Individual #218, Individual #246, and Individual #325), there was documentation that a licensed health care professional: - Conducted monitoring at least every 30 minutes from the initiation of the restraint in 27 (90%) of the instances of restraint. Records that did not contain documentation of this included: Individual #297, 8/27/10; Individual #118, 9/11/10; Individual #297, 9/16/10; and Individual #275, 10/26/10. - Monitored and documented vital signs in 23 (77%). Records that did not contain documentation of this included: Individual #297, 8/27/10 none recorded; Individual #118, 9/11/10 none recorded; Individual #297, 9/16/10 none recorded; Individual #275, 10/26/10 none recorded; Individual #191, 7/18/10 missing blood pressure and pulse for one 15 minute check; Individual #246, 10/15/10; and Individual #92, 11/22/10 had respirations noted as refused. To obtain respirations, the individual's cooperation is not required. To clarify the findings in this area, if the nurse noted a refusal for pulse and blood pressure, it was scored as being in compliance, but because respirations can be obtained without the individual's cooperation, a refusal for this area was scored as not	

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		▪ being in compliance. The "none recorded" indicated that the section(s) on the form were left blank. ▪ Monitored and documented mental status in 27 (90%). Records that did not contain documentation of this included: Individual #92, 11/22/10; Individual #246, 10/15/10; and, Individual #275, 10/26/10 Based on documentation provided by the Facility, no restraints had occurred off the grounds of the Facility in the last six months. Sample #C.3 was selected from the list of individuals who had medical restraint between 7/1/10 and 11/30/10. Of the 296 episodes of medical restraint, only two were listed as for other than pre-treatment sedation, including: Individual #190 on 7/1/10 using an abdominal binder, and Individual #38 on 10/8/10 using a chemical restraint. ▪ The physician's order for the abdominal restraint for Individual #190 was not provided, so a determination of whether or not it was completed and whether it had been monitored appropriately could not be made. ▪ The order for the medical restraint of Individual #38 was available, but it appeared to have been written for pre-treatment sedation, and incorrectly coded in the database. Concerns that need to be addressed for the Facility to attain compliance with this provision of the Settlement Agreement included the lack of consistent timely assessment by the restraint monitors, as well as by licensed health professionals. In addition, quality and completeness of the monitoring performed by the licensed health professionals.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in	A sample (Sample #C.1) of 30 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ In three of the 30, the restraint was chemical for emergency purpose and one to one was not required. In the remaining 27 (100%), continuous one-to-one supervision was provided; ▪ In 30 (100%), the date and time restraint was begun was documented; ▪ In 30 (100%), the location of the restraint was documented; ▪ In 29 (97%), information about what happened before, including the change in the behavior that led to the use of restraint. The checklist for Individual #7 on 8/8/10 at 3:40 p.m. did not include any events preceding restraint, although there was some description in the debriefing. There was considerable variety in the quality of the information provided on the checklists. For example: o The checklist for Individual #218 on 9/24/10 at 2:12 p.m. reported that he was trying to "bust through" the door and punched staff in the neck when they tried to lock the door. Although this provided some valuable	Noncompliance

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	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.	information about the incident, it did not describe what was happening just before this individual headed for the door. That prior information was important to understanding what was causing this individual to become aggressive. o The checklist for Individual #158 on 7/20/10 at 2 p.m. clearly described the prelude to restraint. It identified the individual as being upset: yelling about a packet from her mother. But it was not clear what happened just before the yelling started. Did she get something from her mother? The debriefing provided additional information. It indicated she thought she was supposed to get a package. But what triggered the episode was still not clear. Did the mail arrive and the expected packet was not in it? Did someone mention a packet and she began to obsess about one? The objective of collecting this information is to learn what triggered the start of the episode that ended in restraint, ▪ In 30 (100%), the actions taken by staff prior to the use of restraint were documented by checking the applicable boxes on the checklist. However, to permit adequate review per Section C.8 some narrative is needed. It is not possible to tell from the box checks what order the interventions were employed, or whether the staff were able to follow the directions in the safety plan as they were written. It will be important that training on the checklist emphasize that some narrative is needed and that it must not repeat what is already in the box. ▪ In 30 (100%), the specific reason for the use of the restraint was indicated with at least a checkmark in a relevant box. In 22 (79%) there was an additional comment added to describe more precisely the reason for the restraint was such as "destruction of others property," or "pulled out G-tube," or "biting and banging head." Such comments should prove helpful to those on the Unit Review Team, the Restraint Reduction Team, and the Incident Management Team (IMT) as they review restraints and strategize about ways to reduce their use. ▪ In 30 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was documented; ▪ In 30 (100%), the names of staff involved in the restraint episode were listed; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o In 30 (100%), the observations documented every 15 minutes and at release. Most restraints in the sample were brief and most were monitored more frequently than every 15 minutes. o In 30 (100%), the specific behaviors of the individual that required continuing restraint. In 30 (100%), the care provided by staff during the restraint, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan, although this was not an issue since the range of time in restraint in	

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		this sample, excluding individuals restrained chemically, was two to 13 minutes with one episode lasting 48 minutes. That episode, involving Individual #26 on 7/31/10 at 8:25 p.m. occurred at a time of day when meals would have been concluded. There was nothing in the report that suggested she asked to use the bathroom. ▪ In 25 of 25 episodes of physical or mechanical restraint (100%), the level of supervision provided during the restraint episode was identified; ▪ In 24 of 25 episodes of physical or mechanical restraint (96%), the date and time the individual was released from restraint was provided. In one episode involving Individual #7 on 8/8/10 at 3:40 p.m., which included a chemical restraint, it was not clear when the horizontal restraint was concluded; and ▪ In 26 (87%), the results were documented of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. Records that did not contain documentation of this included: Individual #158, 7/20/10; Individual #118, 9/11/10; Individual #275, 10/26/10; and Individual #275, 10/27/10. In a sample of 30 records (Sample #C.1), restraint debriefing forms, while present in 100% of the records, had been completed correctly for 16 (53%). Concerns noted included the following: ▪ For Individual #7 on 8/8/10 at 3:40 p.m., the monitor did not sign the form; ▪ For Individual #20 on 10/24/10 at 7:38 a.m., the monitor did not sign the form and did not enter the time of arrival of the monitor. ▪ For Individual #268 on 10/5/10 at 1:40 p.m., the chemical section of the form was not completed, and this was for a chemical restraint. ▪ For Individual #246 on 7/9/10 at 9:34 p.m., there appeared to be an error in when the nurse began checks. ▪ For at least 7 forms there were no indications of review by the Unit Incident Management Review Team (UIMRT) or the Incident Management Team (IMT); ▪ For Individual #95 on 9/22/10 at 6:03 p.m., the form was correctly completed, but there were few comments on the chemical consultation portion; ▪ For Individual # 186 on 7/28/10 at 10:03 a.m., the restraint was referred to as a handhold restraint when it was a basket hold. Sample #C.4 was selected using the list the Facility provided called "Individuals Restrained During Time Period Between 7/1/10 and 11/30/10." A sample of 20% of the 25 individuals restrained with chemical restraint other than pre-treatment sedation on the list was selected and included: Individual #95, Individual #109, Individual #268, Individual #275, and Individual #246. This sample of five individuals who were the subject of a chemical restraint were	

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		reviewed. In five (100%), there was documentation that prior to the administration of the chemical restraint, the psychologist was consulted. It was not clear in these cases that there was direct contact between the licensed health care professional and the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. The Facility has been found to be out of compliance with this provision, due to the quality of the information documented with regard to: 1) information about what happened before, including the change in the behavior that led to the use of restraint; 2) the actions taken by staff prior to the use of restraint; and 3) to a lesser extent, the specific reasons for the use of the restraint. As noted above, although some information generally was provided about each of these, the information was not consistently of adequate quality. Each of these elements of information is important as PSTs and staff involved in the overall efforts to reduce the use of restraint at the Facility review restraint episodes. Overall, the quality of the Restraint Debriefing and Face-to-Face forms should be improved by completing forms accurately, and filling in all information particularly dates of review. In addition, there should be documentation of direct contact between the licensed health care professional and the psychologist prior to administration of chemical restraint.	
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:	According to the FY2010 Restraint Monthly Tracking Log, at least 11 individuals had more than three restraints in any rolling thirty-day period from August 1, 2010 to December 31, 2010. Of this group, three individuals were selected for review (reflecting a sample of 27%) including, Individual #246, Individual #275, and Individual #300. Of these individuals, two were identified as individuals who were injured or injured staff during restraints, two were identified as at risk for injuring themselves or peers, and one was listed among those with the highest number of injuries as well as at risk for unauthorized departures. Specific Restraint Checklists and Face-to-Face Assessment, Debriefing and Revision for Crisis Intervention Restraint forms were reviewed for Individual #275 (dated 10/26/10, and 10/27/10), Individual #246 (dated 10/8/10, 10/15/10, and 10/18/10), and Individual #300 (dated 9/22/10, and 9/24/10). In addition, documentation was requested and reviewed for each individual, including the PSP, PSP addendums, psychological assessments, SFBAs, PBSPs, SPCIs, and PSP Monthly Reviews (for the last six months or less), as available. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. Of the three individuals sampled, two (67%) individual's PSTs met to discuss the restraints included in the sample (see the above dates). More specifically, the PST for Individual #275 met on 10/27/10 to discuss the restraints that occurred on 10/26/10 and 10/27/10. In addition, the PST for Individual #300 also met to discuss the restraints that occurred on 9/22/10 and 9/24/10; however, the specific date that this meeting	Noncompliance

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		occurred was unclear. That is, the date "9/20/10" listed on the PSP addendum appeared to be a mistake, because all of the dates discussed in the body of the document were later in the month. The PST for Individual #246, the 3rd individual in the sample, did not meet to discuss all of the restraints selected for the current review (i.e., on 10/8/10, 10/15/10, and 10/18/10). However, the PST did meet on 10/13/10 to discuss restraints that occurred on 10/7/10 (not selected for review), and 10/8/10. It appeared that a subsequent PST meeting for Individual #246 should have been held to discuss the four additional restraints that occurred on 10/15/10 and 10/18/10, but there is no evidence that this meeting took place. To facilitate the current review, although it did not capture all the dates (in which restraints were utilized) that were originally selected, the Monitoring Team utilized the PSP Addendum dated 10/13/10 for Individual #246 to examine Sections C7.a through C.7.g of the Settlement Agreement. Although a meeting was held to discuss the multiple restraints that occurred in a 30-day rolling period in September for Individual #300, no such meeting appeared to have occurred following earlier restraints that met criteria for occurring in a 30-day rolling period in August 2010. At times, documentation provided was inconsistent, likely in error, or incomplete. For example: ▪ Individual #246 appeared to have two restraints on 10/8/10, but only one was listed on the tracking log; ▪ Two restraints occurred (according to restraint checklists) on 9/24/10 for Individual #300, but the later restraint was documented as occurring on 9/25/10 on the restraint monthly tracking log; ▪ As presented earlier, a PSP addendum for Individual #300 was likely incorrectly dated (PSP addendum dated 9/20/10); ▪ PST member signatures were missing from documents (e.g., PSP addendums for Individual #300 (dated 9/20/10), Individual #275 (dated 10/27/10), and Individual #246 (dated 10/13/10); and ▪ Lastly, across all individuals sampled, documentation of the PST meetings in PSP Addendums was typically very brief and narrow in scope. Given the brevity and inadequacy of the meeting minutes, it was very challenging to determine whether or not CCSSLC was meeting key components of the SA. In a few instances below, however, CCSSLC was given the benefit of the doubt when only limited or vague information was provided.	
	(a) review the individual's adaptive skills and biological,	Of the three individuals reviewed, only two (67%) individuals' PSTs reviewed the individual's adaptive skills. The following are examples of individuals for whom this was	Noncompliance

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	medical, psychosocial factors;	done appropriately: ▪ As documented in a PSP Addendum (dated 10/13/10), the PST met to discuss six restraints that occurred between 10/7/10 and 10/8/10 for Individual #246. The discussion appeared to include the potential underlying function of the target behaviors that necessitated the restraints as well as the adaptive responses (e.g., communication skills, diet choices, eating pace) that needed to be encouraged. It was unclear, however, whether or not any data was reviewed regarding progress on replacement behavior acquisition. ▪ There was evidence that the PST discussed the adaptive skills of Individual #275 following six restraints that occurred between 10/26/10 and 10/27/10 (PSP Addendum dated 10/27/10). This included a discussion linking the underlying function of challenging behaviors with identified replacement behaviors. It was unclear, however, if any skill program data was presented and reviewed. The following are examples of where teams failed to do this adequately: • Although the PST reviewed the restraints that occurred in late September for Individual #300 and subsequently recommended a vocational consultation and enhanced supervision, there did not appear to be any substantial discussion related to the adaptive skills targeted as replacement behaviors in the PBSP. In addition, there did not appear to be any data reviewed to assist with evaluating progress on replacement behavior acquisition. Of the three individuals reviewed, only one (33%) of the individuals' PST team appeared to discuss potential biological, medical and psychosocial factors associated with the restraints. The following is an example of an individual for whom this was done appropriately: ▪ As documented in a PSP Addendum (dated 10/13/10) for Individual #246, it appeared that the PST discussed a number of potential factors, including medical and psychosocial variables (e.g., perceived limitations of current placement, diet changes, increased supervision, feelings toward a disruptive peer) related to the target behaviors and resulting restraints. The following are examples of where teams failed to do this adequately: ▪ There was no substantial evidence in the documentation provided for Individual #275 to indicate that the team reviewed relevant underlying biological, medical and psychosocial factors associated with the six restraints that occurred between 10/26/10 and 10/27/10. That is, the team did not appear to conduct a comprehensive review beyond discussing: 1) replacement behaviors, increased level of support, and continued counseling sessions (PSP addendum dated 10/27/10); and 2) a previous medication change (PSP addendum dated 11/10/10).	

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		▪ There was no evidence in documentation provided that demonstrated the PST's discussion of potential medical or biological factors associated with the restraints on 9/22/10 and 9/24/10 for Individual #300.	
	(b) review possibly contributing environmental conditions;	Of the three individuals reviewed, two (67%) individuals' teams reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately: ▪ As documented in a PSP Addendum (dated 10/13/10), it appeared that the PST considered potential environmental factors associated with target behaviors as well as current and previous restraints for Individual #246. ▪ Although there were issues related to signatures and dates on the documentation, it appeared that the PST discussed contributing environmental conditions to the restraints observed on 9/22/10 and 9/24/10 for Individual #300. The following are examples of where teams failed to do this adequately: ▪ There was no evidence in the provided documentation for Individual #275 to indicate that the team reviewed potential contributing environmental conditions. Although potential functions were listed (as identified in PBSP and SFBA), they, as well as other relevant environmental variables, did not appear to be discussed in relation to current episodes of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Of the three individuals reviewed, only one (33%) individual's team reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately: ▪ At the time of the restraints, a SFBA had been previously completed (on 3/12/10) for Individual #275. It appeared that the PST met repeatedly (PSP Addendum on 10/4/10 and 10/27/10), discussed the SFBA, and determined that it was appropriate and effective. The following are examples of where teams failed to do this adequately: ▪ A SFBA was completed on 10/4/10 for Individual #246 just a week prior to the multiple restraints noted between 10/8/10 and 10/18/10. Discussion of the PST appeared to incorporate some of the hypotheses included in this assessment as well as included recommendations related to changes in skill acquisition programming. Although it might be assumed that the recently updated SFBA was current and appropriate, there was no clear determination by the team whether or not events leading to the restraints necessitated a revision of the SFBA. ▪ Although the PST met and discussed potential reasons underlying Individual #300's target behaviors and subsequent restraints, there was no evidence that	Noncompliance

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		the PST considered revising the current SFBA even though identified reinforcers were no longer effective.	
	(d) review or perform functional assessments of the behavior provoking restraints;	See Section C.7.c above.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Of the three individuals reviewed, three (100%) individuals had a PBSP. Of the three individuals in the sample who had PBSPs, the following was found: ▪ Two (67%) specified the objectively defined behavior to be treated that led to the use of the restraint; ▪ Three (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and The following is an example of an individual with an inadequate PBSP: ▪ Self-injurious behavior (SIB) was described in all of the sampled restraints reviewed for Individual #246. However, SIB was not defined in the PBSP (dated 11/17/10). It was unknown if SIB was defined in the previous PBSP Review of documentation provided indicated that the PST decided not to modify Individual #246's PBSP (e.g., to include SIB). The Safety Plans of the individuals in the sample were reviewed. The following represents the results: ▪ In three out of three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; ▪ In two (67%), the maximum duration of restraint authorized was specified; ▪ In three (100%), the designated approved restraint situation was specified; and ▪ In zero (0%), the criteria for terminating the use of the restraint were specified. The following is an example of an individual with an inadequate Safety Plan: ▪ The maximum duration of restraint was not specified in the safety plan (dated 1/12/11) for Individual #300. ▪ All three safety plans reviewed did not specify objectively defined termination criteria. For example, the terms "… when calm" or "stops struggling" were considered vague and could potentially differ across staff.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant	There was no evidence in the sampled documentation to indicate that treatment integrity was examined for any of the PBSPs of the three individuals selected. According to verbal reports from behavioral services staff, treatment integrity data was collected, but not summarized or systematically analyzed. Subsequently, treatment integrity of PBSPs had	Noncompliance

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	treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	not been estimated. At the time of the review, therefore, it was not possible to ensure a high degree of treatment integrity.	
	(g) as necessary, assess and revise the PBSP.	Of the three individuals sampled, there was documentation for one individuals (33%) indicating that their PBSPs had been reviewed. The following is an example of an individual for whom this was done appropriately: ▪ There was evidence to indicate that, following the six restraints of Individual #274, on 10/26/10 through 10/27/10, the PST agreed that the behavioral programming (i.e., SPCI, SFBA, and PBSP) was appropriate and effective. The following are examples of where a team failed to do this adequately: ▪ At the time of the restraints, Individual #246 had a PBSP implemented to address aggression and unfounded allegations. Documentation provided for Individual #246 (PSP Addendum dated 10/13/10) reflected the PST's decision to not revise the PBSP at that time after other changes in programming and supports were recommended. It was unclear, however, whether or not behavioral data was presented and reviewed. In addition, it was unclear why the team did not consider including SIB in the PBSP given that aggression and SIB were observed in all the incidents that led to restraint. ▪ Although the PST met (on or around 9/20/10) and discussed multiple restraints used with Individual #300 in late September 2010, reference to revising related strategies within her PBSP, despite notation that identified reinforcement strategies were not working, was not noted.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	Restraints were reviewed at the Unit Team Meeting on the day following the restraint and by the Incident Management Team, usually on the next business day. In addition, the Restraint Reduction committee met weekly to review restraints that had been used. A sample of documentation related to 30 incidents of non-medical restraint was reviewed (Sample #C.1), including Unit Team meeting minutes, incident management review team meeting minutes, Restraint Reduction Committee minutes and PSP addenda. This documentation showed that: ▪ In 30 (100%) records, this review occurred within three days of the restraint episode. However, it was not clear from the minutes that the UTM did more than review the restraint report for accuracy and refer it for correction. Attendance at one UTM meeting revealed that there was discussion about the restraint use and the reasons for it. If the minutes did contain referrals for action or follow-up, it was not clear how this would be tracked in the minutes. There was usually a	Noncompliance

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		follow-up meeting held by the Personal Support Team and addenda added to the PSP to reflect their discussion which sometimes included referral back to the psychologist for an amendment to the Behavior Support or Safety Plan. ▪ However, as noted above with regard to Section C.7, teams did not consistently review and/or review appropriately individuals PBSPs. As a result, revisions were not always made as necessary and appropriate.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Training should be provided to direct support professionals to ensure that they are prompting the use of replacement behaviors and other coping strategies and documenting their use adequately, when appropriate, on restraint checklists.
2. Desensitization plans should be individualized. Assessments should be conducted to identify individual-specific preferences, current coping skills/deficits, and likely effective supports. Once identified, these elements should be incorporated into plans and implemented across settings, including opportunities to practice coping skills in the natural setting (dental office).
3. Desensitization plans should mirror the improved Skill Acquisition Plans (SAPs), which are discussed in further detail with regard to Section S of the Settlement Agreement. That is, elements currently found with SAPs, such as behavioral objectives, differential reinforcement, etc., are critical to the success of any skill acquisition plan and, therefore, should be the foundation of these desensitization plans as well.
4. The PST of each individual receiving sedation or protective support for medical/dental procedures should clearly indicate within the PSP the rationale underlying the team's decision to utilize (or not) desensitization plans.
5. Progress on desensitization plans should be regularly documented and summarized. Such information should be summarized in Monthly Behavioral Services PSP Monthly Reviews (i.e., along with other behavioral data) or in Monthly PSP Reviews (i.e., along with other skill program data). In addition, efforts should be made to ensure that all documentation accurately and consistently reflects the implementation of these plans.
6. The Facility should ensure that restraint monitors are in place within the 15 minutes the Settlement Agreement requires.
7. The Facility should review its systems and make modifications as necessary to ensure the pharmacist and psychiatrist complete their reviews of chemical restraints and document the reviews on the Debriefing Form.
8. The Facility should ensure that a licensed health care professional monitors and documents vital signs and the 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.
9. The Facility should ensure that nursing assesses and appropriately documents any restraint-related injury.
10. The quality of the documentation of the events preceding the restraint should be improved to provide an understanding of what happened to initiate the chain of events that resulted in restraint, as well as the specific actions staff took.
11. The quality of the Restraint Debriefing and Face-to-Face forms should be improved by completing forms accurately, and filling in all information particularly dates of review.
12. There should be documentation of direct contact between the licensed health care professional and the psychologist prior to administration of chemical restraint.
13. If not already in place, a standard format should be developed and implemented for PSP addendum meetings following more than three restraints in a rolling 30-day period. Such a format should be used to ensure discussion and documentation of all the key elements of the SA. This format should address items C7.a – C7.g. as well as highlight the rational as to why the PST decided to or not to revise the SFBA, PBSP, and/or SPCI. The format also should be used to document whether or not relevant skill acquisition and corresponding target behavior data was available and reviewed.

14. Objectively defined termination criteria for restraints, and the clear maximum duration of restraints should be included in all Safety Plans.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Policy and Procedure Manual Section D, including Policy #021 and related procedures D.1 through D.20, and Policy #002.2 and related procedures DD.1 through DD.18, updated through December 2010; o CCSSLC Plan of Implementation, dated 9/27/10; o Settlement Agreement Cross-Referenced with ICF-MR Standards, Section D - Protection From Harm, revised August 2010: for five reports completed in November 2010 by a Program Compliance Monitor; o OIG Investigations – Suspect Status as of 1/6/11; o CCSSLC Preventing Abuse is Everyone's Responsibility flyer, revised 10/22/10; o Letter to family members and guardians from the Incident Management Coordinator, undated; o Curricular materials for abuse, neglect and exploitation training with revisions through 11/12/2010; o Section D – Protection from Harm – Abuse, Neglect and Incident Management monitoring tool, revised August 2010; o Section D – Protection from Harm – Abuse, Neglect and Incident Management Guidelines for Completing Tool, revised August 2010; o CCSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 9/10/10; o QMRP Check Sheet, dated 7/23/10; o Sample #D.1: This included a sample of 41 DFPS (approximately 20% of the 200 conducted between 7/1/10 and 11/30/10) investigations of abuse, neglect, and/or exploitation reports. This sample included the following investigation numbers: #37672020, #37933366, #38321386, #37810600, #38303320, #38287728, #37847063, #38033800, #37981126, #38329844, #38324592, #38274672, #37601781, #38354152, #37618400, #38280616, #37976940, #38294866, #37678800, #38198441, #38031841, #38164441, #38056300 #37556020, #37645400, #37331040, #37802440, #38258741, #37824840, #37940240, #38313925, #38322695, #37803200, #38133883, #37434606, #38288103, #38041420, #38211541, #37839580, #38286115, and #37830884; and o Sample #D.2: This included a sample of seven Facility investigations (approximately 20% of the 34 investigations that occurred between 7/1/10 and 11/30/10). Some of these were investigations that DFPS had referred to the Facility, while others were investigations the Facility completed related to serious injuries or deaths. This sample included the following investigations: #461897, #473150, #471676, #473581, UI report unnumbered for Individual #88 on 8/23, UI report unnumbered for Individual #42 on 9/27/10, and UI report unnumbered for Individual #317 on 10/20/10.

- **Interviews with**:
  - Twenty staff members in various units;
  - Daniel Dickson, Director for Quality Enhancement;
  - Cheryl Huff, Incident Management Coordinator;
  - Mark Cazales, Assistant Director of Programs; and
  - Iva Benson, Facility Director.
- **Observations of**:
  - Living Units including: Apartments 522A, 522B, 522C, 522D, 515, 516, 511, 514, and 517;
  - Vocational Building 513;
  - Atlantic Unit Management Team Meeting, at 10 a.m. on 1/4/11; and
  - PSP meetings for Individual #298 and Individual #126.

Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section D of the Settlement Agreement, the Facility found that it achieved compliance with the majority of indicators. It assessed itself to be in substantial compliance with 16 out of 23 indicators.

Quality Assurance Activities to ensure compliance with this section included development of a monitoring tool and guidelines modeled on the one designed by the Monitoring Teams, and the application of that tool to selected samples. This represented an important step toward the Facility's self-assessment of compliance. The Facility used the monitoring tool to review a sample of five reports of investigations conducted in November. In the Monitoring Team's review of three of the same records (#473581, #38288103, and #473352), it appeared that the Facility's reviewer had identified issues with the reports and had summarized those issues accurately in the comments section of the form. In the sections below, the Monitoring Team has commented on the concordance between the Facility's findings and the Monitoring Team's findings.

A copy of the review form was used to display the data collected from all five monitoring reviews to provide a summary. It would be helpful for the Facility reviewer to identify the reports by case number on the summary form to assure accuracy in the future.

The average number of Unusual Incidents and DFPS cases per month was approximately 40. If five reports were reviewed monthly, that would be approximately a 12.5% sample. A slightly larger sample of eight reports, or 20%, is recommended as a goal. However, the quality of the monitoring should not be sacrificed to quantity.

Summary of Monitor's Assessment: CCSSLC had demonstrated significant progress toward compliance in the area of protection from harm. Thirteen of the 22 indicators in this section were found to be in substantial compliance and nine were found to be noncompliant. Highlights of their progress included:

- Policies and procedures had been established to address reporting and investigation of unusual incidents and to require reporting of abuse, neglect, and exploitation.
- Procedures were in place to discourage retaliation against reporters of abuse and actions were being taken to address any allegations of retaliation. However, this was an area that needed

	continued attention. ▪ Actions to protect individuals who were involved in unusual incidents or abusive situations were taken quickly. Staff alleged to have been abusive or neglectful were routinely put on temporary work reassignment to remove them from direct contact with individuals served. ▪ Staff were being trained in reporting abuse and used the information on their identification badges to prompt their actions. ▪ A flyer had been developed and mailed to the families or legally authorized representatives of all individuals residing at CCSSLC to inform them of their rights to report abuse, neglect and exploitation and the processes and protections for doing so. However, there was not sufficient evidence that individuals were being provided this information at their annual meetings. ▪ There was evidence of cooperation with DFPS investigations and with investigations by law enforcement and the Office of the Inspector General. To continue its progress toward full compliance with Section D, the Facility will need to fine-tune its processes to make them timely, to provide for documentation of supervisory reviews of investigations and to ensure that investigators are fully trained in the requisite investigatory skills, as well as skills in working with people with developmental disabilities. Two key processes needed additional development: the semi-annual audit of injuries, which was not in place, and the follow-up on recommendations from investigative reports, which were not documented to conclusion.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The Facility's policies and procedures: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. In practice, the Facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: ▪ Posters were placed in residences, vocational locations, and offices to reiterate the Facility's zero tolerance for abuse; ▪ Staff identification badges included the instructions on reporting abuse; ▪ Staff interviewed demonstrated the value of these badges by routinely pointing to them to explain how they would report abuse.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management		

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	policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to CCSSLC Policy #021.IV.A all, staff were required to report abuse, neglect, and exploitation within one hour by phone to DFPS and to the Director or her designee. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, CCSSLC Policy #002.2 required staff to report unusual incidents within one hour to the Director or designee. Both Sections D.2 and DD.5 of the Facility Policy and Procedure Manual required immediate (within one hour) reporting to the Director of serious incidents. Since there was no reference to the manner of reporting in these sections, the assumption was that the reporting is to be verbal. Policy #002.2 described how the Facility was to report incidents to the DADS State Office. It appeared that the process was for the staff member who witnessed or became aware of an incident to call the Incident Management Coordinator (IMC) or designee to report the unusual incident, and the call triggered the start of the Unusual Incident Report by the IMC's office. This policy was consistent with the requirements of the Settlement Agreement, but needed a clearer explanation of what form the report was to take (i.e. phone call, a written report, or whatever was expected.) In the document entitled "CCSSLC Abuse Neglect and Exploitation – Quarterly Trending Report from 9/1/2010 to 11/30/2010," which contained data by month since September 2009, the Facility provided trending reports on the number of DFPS cases by month and by quarter. This quarterly report also showed the number of allegations for the quarter. According to Facility data provided in this report, the following represents the numbers of abuse, neglect and exploitation allegations and cases that occurred at the Facility between 9/1/2010 and 11/30/2010: ▪ Total abuse, neglect and exploitation allegations: 261 o Confirmed - 14; o Unconfirmed - 206; o Inconclusive – eight; o Unfounded - 14; and o Administrative Referral – 19. The total abuse, neglect, and exploitation cases for the year beginning 12/1/09 and ending 11/30/10 was 388. The number of cases for the quarter, from 9/1/2010 to 11/30/2010, was 98. Often, more than one allegation was involved in each case resulting in the difference in numbers.	Noncompliance

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		It appeared from the trending report that the Facility began trending allegations in September 2010. The report did not show any earlier data for comparison purposes. According to Facility data provided in the document entitled "CCSSLC Unusual Incidents – Quarterly Trending Report from 9/1/2010 to 11/30/2010," which included data from September 2009 forward, the following represented the numbers of unusual incidents that occurred at the Facility for the one-year period from 12/1/09 through 11/30/10: ▪ Total unusual incidents – 124, including: o Deaths – four; o Serious injuries – 22; o Sexual incidents – 20; o Suicide threat – Credible – 11; o Suicide threat – Non credible – 48; o Unauthorized Departure – 13; o Choking – four; and o Other – four. Based on interviews with 20 staff responsible for the provision of supports to individuals, 20 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Two samples of investigations were selected for review. These included: ▪ Sample #D.1 which included a sample of 41 DFPS (approximately 20% of the 200 conducted between 7/1/10 and 11/30/10) investigations of abuse, neglect, and/or exploitation reports. This sample included the following investigation numbers: #37672020, #37933366, #38321386, #37810600, #38303320, #38287728, #37847063, #38033800, #37981126, #38329844, #38324592, #38274672, #37601781, #38354152, #37618400, #38280616, #37976940, #38294866, #37678800, #38198441, #38031841, #38164441, #38056300 #37556020, #37645400, #37331040, #37802440, #38258741, #37824840, #37940240, #38313925, #38322695, #37803200, #38133883, #37434606, #38288103, #38041420, #38211541, #37839580, #38286115, and #37830884. ▪ Sample #D.2 included a sample of seven Facility investigations (approximately 20% of the 34 investigations that occurred between 7/1/10 and 11/30/10). Some of these were investigations that DFPS had referred to the Facility, while others were investigations the Facility completed related to serious injuries or deaths. This sample included the following investigations: #461897, #473150, #471676, #473581, UI report unnumbered for Individual #88 on 8/23, UI report unnumbered for Individual #42 on 9/27/10, and UI report unnumbered for Individual #317 on 10/20/10.	

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		Based on a review of the 48 investigation reports included in both Sample #D.1 and Sample #D.2: ▪ A total of 39 (81%) included evidence that cases of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Reports that did not indicate timely reporting were: #37672020, #38303320, #38324592, #37976940, #38198441, #38056300, #38258741, #37824840, #37434606, and #38286115. The range of delay was from a few hours to two or more months. ▪ A total of 48 (100%) included evidence that cases of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. However, it was not clear that staff who might have reported an allegation to DFPS, also had reported it to the Facility Director as required. Since allegations to DFPS were anonymous, it is not known who the reporter was. Whether staff failed to report to the Director could only be determined if the investigation resulted in a confirmation of abuse, neglect, or exploitation, and the investigation showed that there were staff who witnessed the incident who did or did not appropriately report the allegation. Nine of the investigations in the sample confirmed the allegation either in full or in part. In #37601781, the alleged abuse, dragging an individual by her gait belt, was reported to DFPS and DFPS reported it to the Facility. Both the reports DFPS and the Facility completed stated that several people witnessed the action, but did not intervene, and this was confirmed to be neglect. What was not clear was whether all of these witnesses reported the allegation to DFPS, and whether any of the witnesses reported the incident to the Director or her designee as was required or instead relied on the shield of anonymity provided by DPFS. The Facility had a standardized unusual incident investigation format that included the initial information collected when the incident was reported verbally. The format was clear, concise and useful for both investigations conducted solely by the Facility and for reviews conducted in conjunction with DFPS investigations. The format met generally accepted standards and contained information necessary for adequate follow-up as well as tracking and trending of incidents. Based on a review of 48 investigation reports included in Sample #D.1 and Sample #D.2, 48 (100%) contained a copy of the report utilizing the required standardized format. The Facility remained out of compliance with this portion of the Settlement Agreement. In addition to increased efforts to remind staff of their responsibilities with regard to the timely reporting of abuse and neglect, ongoing in-service training should focus on delineating the more subtle forms of abuse (such as dragging a person by a gait belt), and reinforcing with staff their responsibilities to report these allegations in addition to more	

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		blatant abuse (e.g., hitting an individual).	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	According to Section D.2 of the Facility Policy and Procedure Manual, any employee, agent or contractor must report the abuse to the Director and to DFPS by phone within the hour, act to stop the abuse, secure medical treatment, secure evidence, and comfort the victim. Based on a review of 41 investigation reports included in Sample #D.1, 35 (85%) of alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. In those cases where the alleged perpetrators were not removed, in three cases more than three months had past since the alleged event. In three cases, including #37434606, #37830884, and #37678800, there appeared to be situations where the event was not significant enough to warrant removal of staff (i.e., the preliminary assessment showed the employee posed no risk) or it was not clear which staff was involved. In case #38274672, the allegation appeared to have been handled by DFPS as if it were a streamlined case, where the reporter was known to make frequent spurious allegations. However, since CCSSLC did not agree to treatment of cases as streamlined, it was not clear why it was handled in this way. This case pointed out the difficulty inherent in investigating cases where the reporter has a history of false reporting. Even when there was no intent to "streamline" the case, the history can be difficult to overcome. Based on a review of 35 investigation cases where staff had been removed and the list of staff removed from duty and returned, a total of 35 (100%) showed that the staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation, or the conclusion of the investigation allowed their return to direct contact duties. Based on a review of the 48 above cases, it was documented that adequate additional action was taken to protect individuals in all cases (100%). For example: ▪ With regard to case #38303320, where the gastrostomy feeding tube (g-tube) button was discovered missing, the individual received medical attention to determine if she had swallowed the button and monitoring to assure her health was not compromised. ▪ With regard to case #37645400, where the individual injured her knee getting out of a new bed that was too tall for her, the individual received medical attention for her injuries and the bed was immediately replaced with one at a more suitable height. The higher bed was returned for refund. ▪ In case #38274672, where the perpetrator of the allegation was not known, the home was monitored for signs of possible abuse. ▪ In a report of injury involving Individual #11, he broke a picture on the wall in his	Substantial Compliance

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		room that had glass in the framing. There was an immediate search of the house for any other pictures with glass (there were none), and other glass ornaments.	
	(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 Section D.1 of the Facility Policy and Procedure Manual, all staff must attend competency-based training in course ABU0100 at pre-service and annually thereafter. This was consistent with the requirements of the Settlement Agreement. In response to a document request, the Facility provided the curriculum in use to train staff on abuse, neglect and exploitation. The document was not labeled with the ABU0100 course number, but it appeared to be the curriculum for that course. A review of the training curricula related to abuse and neglect was reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: ▪ In relation to the requirement for training to be competency-based, the training included a post-test in which the employee must demonstrate a working knowledge of the policies and procedures related to abuse investigation. ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 24 staff records (Sample #C.2), showed that 100% of these staff had completed competency-based training on abuse and neglect and were not delinquent in annual refresher training. Based on interviews with 20 staff: ▪ All 20 (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and ▪ All 20 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their	According to Section D.1 of the Facility Policy and Procedure Manual, all staff must sign a statement acknowledging zero tolerance for abuse, neglect and exploitation and their obligations to report any suspicions. A sample of 24 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 24 staff, 23 (96%) had signed annual acknowledgments. The missing acknowledgement was for employee #213777. This compared favorably with CCSSLC's own review as reported in the POI of 100% compliance. In 11 of 41 cases in Sample #D.1, the incident of alleged abuse was reported more than one hour after it occurred (case numbers, 38286115, 37839580, 37434606, 38313925,	Substantial Compliance

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	reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	37824840, 38258741, 37556020, 38164441, 37678800, 37976940 and 38303320). In another five cases, the time of the alleged abuse could not be determined exactly, so whether the reporting was timely could not be established. When reporting was delayed, the delay was a matter of a few hours to as much as two months. The lengthy delays were related to allegations of verbal abuse, and in one case physical abuse. Due to DFPS's policy of not identifying the reporter, it could not be determined whether or not staff made the allegations, or individuals, visitors, or family members. There were several instances in which, based on the information provided in the allegation, it appeared the allegation was most likely made by the individual and were subsequently not confirmed.	
	(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 Section D.19 of Facility policy manual, QMRPs were to send a copy of the Abuse, Neglect, and Exploitation Resource Guide, and CCSSLC Preventing Abuse is Everyone's Responsibility flyer, revised 10/22/10, to families and Legally Authorized Representatives (LARs) prior to the annual Personal Support Plan (PSP) meeting, and to provide a copy to the individual at the meeting. The QMRP was to describe the process to the individual at the meeting. A review was conducted of the flyer used to educate individuals and families about their rights with regard to reporting. The flyer condensed a lot of information into two pages. It contained the basic information about signs and symptoms of abuse and neglect, provided phone numbers to call, and emphasized the need to stop any abuse and safeguard the individual first and foremost. Based on a review of five individuals' PSPs, including Individual #70, Individual #32, Individual #10, Individual #147, and Individual #94, there was no documentation to show that any of the individuals had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation at the PSP meeting. Based on the Monitoring Team's attendance at two PSP meetings (Individual #298 and Individual #126), information about reporting allegations of abuse was not discussed or distributed during the meeting. The QMRP Check-sheet reminded the QMRP to provide the Abuse Resource Guide to the person. The PSP Meeting/Documentation Monitoring Checklist did not include an indicator to check for provision of this information. In interviewing a sample of 10 individuals, all 10 were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. Since incidents of abuse, neglect and exploitation are reported anonymously, it was difficult to find a measurement for whether or how well individuals were being assisted to report. However, in the context of the sample of investigative reports, there were several mentions of staff escorting an individual to the phone or asking if he/she wanted to make a report.	Noncompliance

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		The Facility had developed materials and a mechanism for informing individuals and their LARs of the methods for reporting abuse and neglect. However, the mechanism for informing individuals included discussion and provision of written materials at the PSP meeting. Neither documentation nor on-site observations confirmed that this was happening. Although progress had been made in this area, the Facility was not in compliance with this requirement.	
	(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 Section D.20 of Facility policy and procedure manual, all living units and day programs were to have the "Rights Poster" on display. A review was completed of the posting the Facility used. It included 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. Observations by the Monitoring Team of nine of 17 living units and day programs on campus showed that all nine (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. In one of the nine buildings, Apartment 522C, the posting had been temporarily removed to allow for painting and was in place by the next day.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to Facility Policy D.11, all allegations that might involve criminal activity must be reported to DFPS who will then notify the appropriate law enforcement authority. Based on a review of 41 allegation investigations completed by DFPS (Sample #D.1), in 26 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 26 (100%). Based on a review of seven investigations completed by the Facility (Sample #D.2), no referrals were made to law enforcement and none appeared necessary.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment,	According to Section D.6 of the Facility Policy and Procedure Manual, all forms of retaliation against individuals, their families and LARs, as well as employees who reported allegations of abuse/neglect/exploitation in good faith is prohibited. These individuals can immediately report any alleged incident of retaliation to the Facility Director or her designee. Phone numbers for other reporting alternatives also were provided in the poli*cy.* Based on interviews with the Assistant Director for Programs, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be	Substantial Compliance

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	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.	tolerated: ▪ When the Assistant Director for Programs received a report of retaliation, he forwarded it to the Office of the Inspector General. ▪ OIG would respond as to whether they will investigate. ▪ A list of OIG investigations of retaliation reports was produced, and indicated nine cases in process. ▪ The Review Authority Team reviews all allegations and commented on those that need some action such as disciplinary action against offenders. Based on interviews with 20 staff, 18 (90%) reported they were confident that retaliation would not be tolerated. The two remaining staff indicated a heightened level of concern that if they reported abuse, they could face retaliation (a score of eight to nine on a scale of one to 10, where 10 is the most concern.) The Facility's tracking of this element found that 96% of staff in a 257 sample understood how to report retaliation as reported in the POI. Based on interviews with 10 individuals served by the Facility, 10 (100%) reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there was one concern noted related to potential retaliation. The concern noted included: ▪ Related to Investigation #37847063, there was a report of retaliatory behavior by the person who was alleged to have perpetrated abuse. She was dismissed. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who in good faith had reported an allegation of abuse/neglect/exploitation. A list of OIG investigations was produced with nine names of staff. In three cases the OIG had completed their report. The length of time between the initiation of the report and the conclusion ranged from two to five months. Once the report was received, if the Facility must take disciplinary action, additional time was required. The following describes actions that were taken in an attempt to prevent such retaliation in the future: ▪ Posters reminding staff that retaliation will not be tolerated; ▪ Training emphasized the Facility's position on retaliation; and ▪ The activity of OIG may be a deterrent.	
	(i) Audits, at least semi-annually,	According to the Quality Enhancement Director and to the CCSSLC Plan of Improvement	Noncompliance

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	to determine whether significant resident injuries are reported for investigation.	dated 9/27/10, the Facility was drafting a procedure for semi-annual audits. There was no process in place at the time of the Monitoring Team's review.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	According Section DD.1 of the CCSSLC Policy and Procedure Manual, all staff who engaged in Facility investigations had to attend Comprehensive Investigator Training (CIT0100) and People with MR (MEN030) prior to assignment as an investigator and prior to completing an Unusual Incident Report investigation. In addition, the Incident Management Coordinator, Campus Administrator, Campus Coordinator, and Facility Investigators had to complete Conducting Serious Investigations or Fundamentals of Investigation training (INV0100), and a class on Root Cause Analysis within six months of employment. CCSSLC Policy #002.2 at H. required staff assigned to investigations to be outside the direct line of supervision of the alleged perpetrator. The policies and procedures at the Facility: ▪ Described in a comprehensive fashion the conduct of all such investigations; ▪ Required that investigators be qualified by taking the required courses; ▪ Required that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and ▪ Require that investigators be outside of the direct line of supervision of the alleged perpetrator. Training curricula was reviewed for the Department of Family and Protective Services (DFPS) and Facility investigators. This review revealed the following: ▪ DFPS training for investigators, Instructor Led Skills Development (ILSD), and Instructor Led Advanced Skills Development (ILASD), Texas Department of Family and Protective Services, dated March 2009. ILASD training consisted of 10 modules, including one on interviewing persons with developmental disabilities. The module contained performance goals and objectives, but it was not clear whether the investigator's performance was to be tested or monitored	Noncompliance

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		in practice to see if the lessons in the module had been learned. Most modules contained exercises to strengthen the training, but it was not clear whether the investigator must demonstrate comprehension to be judged successful in the course. ▪ Facility investigators had received their training on the conduct of investigations from Labor Relations Alternatives, a known and respected provider of investigation training. While they took the LRA training and their files contained copies of the certificates awarded by LRA, it was not clear that they also had participated in the competency test that LRA offered. While the training provided opportunities for practicing investigation skills, it did not render a determination as to whether the investigator was competent in the skills trained. In response to a document request, a list of eight DFPS investigators, their training transcripts, and a crosswalk to the titles of courses, which had changed, were provided. The training records for these investigators were reviewed with the following results: ▪ Six out of the eight DFPS investigators whose names were provided (75%) had completed the requirements for investigations training. The two investigators who had not been trained were recently hired and had not completed their training. Their names did not appear as investigators on the reports reviewed in Sample #D.1. However, names of two investigators who were not on the provided list did appear in the sample and no record of their training was provided. The file numbers for those investigations were: #37556020, #37645400, #37802440, #37830884, #38041420, #38133883, #38329844, #37434606 (all the same investigator), #38287728, #38321386, and #38354152. ▪ Six out of the eight DFPS investigators whose names were provided and/or appeared on investigation reports (75%) had completed the requirements for training regarding individuals with developmental disabilities. As noted above, training transcripts for two investigators who had completed investigations were not provided. The Incident Management Coordinator oversaw the investigations at the Facility. There were two full-time investigators. In addition, the Campus Administrators and Campus Coordinators (nine staff) had been trained to conduct investigations and could be called upon to assist when needed. The training records for these investigators were reviewed with the following results: ▪ Eleven out of 12 Facility investigators (92%) had completed the requirements for investigations training. ▪ Eight out of 12 Facility investigators (67%) had completed the requirements for training regarding individuals with developmental disabilities.	

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		The IMC and the two full-time investigators had received the required training. The person missing the investigation training had not conducted any of the investigations in the sample. The staff missing the training regarding individuals with developmental disabilities might have participated in some of the Facility investigations, but they were not the person responsible for the investigation. These staff should complete their training, because at any time, they could be called upon to initiate or complete an investigation. While at any time, some investigators might lack training due to being newly hired or assigned to investigations, it will be important to continue to assure that those investigators do not conduct investigations until their training is completed.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on Section DD.10 of the Facility Policy and Procedure Manual, Facility staff were required to cooperate with DFPS in conducting investigations of abuse and neglect. This included suspending internal investigations and interviews until DFPS had completed their investigation. 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 Sample #D.1, the DFPS investigations and the sub sample of corresponding Facility investigations, and Sample #D.2, which consisted of Facility investigations. ▪ Review of the investigation files in Sample #D.1 showed that in 41 out of 41 investigations (100%), Facility staff cooperated with DFPS investigators. ▪ Review of the investigation files in Sample #D.2 showed that in seven out of seven investigations there was cooperation with outside entities. This was a similar finding to when compared with the CCSSLC monitoring of five Facility investigations that showed cooperation with outside entities.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found:	Substantial Compliance

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		▪ Of the 41 investigation records from DFPS (Sample #D.1), 29 had been referred to law enforcement agencies. For 29 out of these (100%), there appeared to be adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the seven investigation records from the Facility (Sample #D.2), one had been referred to law enforcement agencies. The investigation involved Individual #11 on 8/23/10 (no file number appeared on the report.) In this case there was adequate coordination to ensure that there was no interference with law enforcement's investigations. This compared favorably with CCSSLC's own finding of cooperation with law enforcement investigations as reported in the POI.	
	(d) Provide for the safeguarding of evidence.	Section D.5 of the Facility Policy and Procedure Manual described the process for securing evidence, which included collecting any physical evidence, storing it in a paper bag, labeling it, and safeguarding it until the investigator took possession of it. Evidence was to be stored in the safe under the control of the Incident Management Coordinator. Documentary evidence was to be stored or copied to prevent alteration until the investigator collected it. Section D.5 described in detail the securing of evidence in the IMC's safe and who had access to that safe. According to the policy, an Incident Management (IM) log must be kept in a locked cabinet in the IM Administrative Assistant's office with specific information about any access to the evidence. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2): ▪ Evidence that needed to be safeguarded was properly secured and safeguarded in 100% DFPS investigations; and ▪ Evidence that needed to be safeguarded was properly secured and safeguarded in 100% Facility investigations. Most of the evidence that was necessary for these investigations was documentary or testimonial. In a few cases, pictures and diagrams were collected or developed. In an increasingly larger number of cases, the video surveillance tapes were requested and used as a part of the evidence considered in the investigation. This occurred at least nine times in the 41 investigations in sample #D.1. The Facility policy did not contain a section on video surveillance with guidelines on when and how to use it for investigative purposes. Consideration should be given to adding a policy/procedure related to the use of video surveillance tapes in investigations.	Substantial Compliance

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	(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.	Based on Section DD.10 and DD.11 of the CCSSLC Policy and Procedure Manual, 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; ▪ Required a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed 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 (Sample #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 DFPS investigations: ▪ Thirty-four out of 41 (83%) 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. The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary: o Three involved allegations of verbal abuse (#38041420, #38280616, #37678800). In discussions with DFPS officials it was learned that they had a prioritization practice that allowed some allegations, such as verbal abuse, to be investigated after the initial 24 hours. o Five involved neglect or physical abuse allegations: #37981126 involved use of an ARJO lift; #37601781, involving physical abuse; #37556020, in which staff was asleep on duty; #38313925, involving physical abuse; and #38286115, which had been reported two months late, probably by the alleged victim. ▪ Thirty-eight out of 41 (93%) were completed within 10 calendar days of the incident. However, for the 41 investigations, the supervisor sign-off was not present in the record to indicate that the investigations were final. It is the Monitoring Team's understanding that DFPS supervisors routinely review and approve reports. It has been agreed that in the future DFPS will send copies of the approval page with investigations to CCSSLC, until such time as they can make an electronic adjustment so that the supervisor's signature will appear on the investigation report. The three reports that were past 10 days were:	Noncompliance

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		#37981126, #37331040, and #38033800. ▪ For the four that were not completed within 10 days, three (75%) 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. ▪ Forty-one (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 10 of the investigations reviewed, recommendations for corrective action were included. In 10 of the investigations (100%), the recommendations were adequate to address the findings of the investigation. The following are examples of investigations that included appropriate recommendations: o In #38303320, the investigator noted that the abdominal binder the individual was wearing was supposed to be part of his Behavior Support Plan, but that plan was out-of-date. A recommendation was included to address this finding; o In #38033800, a case involving the failure to ensure the individual's wheelchair belt was secured, the investigator noted that routine supervision did not appear to convey the duty to safeguard the individual during transport. This was addressed in a recommendation; and o In #37824410, involving a situation where staff suspected that the individual who fell from his wheelchair had unbuckled his safety belt, the investigator recommended the buckle be repositioned so that the individual could not reach it easily. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: o Seven out of seven (100%) commenced within 24 hours of notification or discovery 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 the Facility being notified of the serious incident. o One out of seven (14%) were completed within 10 calendar days of the incident, including sign-off by the supervisor to indicate that the investigation and report was finalized. However, all reports were completed except for the supervisor's signature within the 10 days. In these six reports, the supervisor's signature was either missing or after the 10-day period.	

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		o No written extensions to provide for additional time for supervisory review and signatures were in place. o All 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. o In five of seven of the investigations reviewed, recommendations for corrective action were included. In three of the five investigations (60%), the recommendations were adequate to address the findings of the investigation. The following is an example of an investigation that included appropriate recommendations: ▪ In the case involving Individual #88 on 8/23/10, the individual injured his hand when he broke a picture frame containing glass in his bedroom. The PST took immediate steps to check all pictures to assure there was not further possibility of injury. The investigator noted that the individual's Behavior Support Plan was out-of-date and recommended it be updated. The following were the investigations for which concerns were noted with regard to the adequacy of the recommendations all of which involved nursing notes. It was not clear in the investigation reports what needed to be done apart from assuring that they were legible and that signatures were legible: ▪ In one case, the investigator referenced material that was not in the file provided (case # 46189782.) ▪ The other cases that did not have adequate detail in recommendations related to nursing were case #473159 and #473581. A finding of noncompliance has been made. For the DFPS investigations, the issues that were identified included the failure to commence and/or to provide documentation to show the commencement of investigations within 24 hours, and supervisory review and/or documentation of such not being completed within the 10-day time frame. For the Facility investigations, the issues that were identified included supervisory review and/or documentation of such not being completed within the 10-day time frame, and recommendations not being adequate to address the findings of the investigation.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear	Based on a review of CCSSLC Policy #002.2 and the related procedure at DD.11 of the CCSSLC Policy and Procedure Manual, the policy required that: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion;	Noncompliance

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	basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	▪ The report utilized a standardized format that set forth explicitly and separately:
		o Each serious incident or allegations of wrongdoing;
		o The name(s) of all witnesses;
		o The name(s) of all alleged victims and perpetrators;
		o The names of all persons interviewed during the investigation;
		o 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;
		o All documents reviewed during the investigation;
		o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;
		o The investigator's findings; and
		o The investigator's reasons for his/her conclusions.
		
		The Facility Investigations were reported on an Unusual Incident Investigation form, revised 11/5/10. The form had at least 21 sections, designed to be filled out electronically as the investigation progressed. The form included such additional information as the dates and times of notifications of interested parties, the staffing level assigned to the individual, the time nursing intervention was provided and results of Program Support Team (PST) and Review Authority Team Meeting (RATM) deliberations. The official files were organized according to a checklist, in binders with separators between documents delineated on the checklist.
		
		To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #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 DFPS investigations:
		▪ In 41 out of 41 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 41 (100%), each serious incident or allegations of wrongdoing;
		o In 41 (100%), the name(s) of all witnesses;
		o In 41 (100%), the name(s) of all alleged victims and perpetrators;
		o In 41 (100%), the names of all persons interviewed during the investigation;
		o In 41 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of	

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		questions posed, and a summary of material statements made; o In 41 (100%), all documents reviewed during the investigation; o In 0 (0%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. In a meeting in December 2010, DFPS indicated that investigators reviewed previous investigations electronically and only commented in the investigation report if there was relevance. However, this did not provide a mechanism for the Monitoring Teams to ascertain whether this had been done. DFPS agreed to include a statement that would describe the results of these reviews in future investigations. o In 41 (100%), the investigator's findings; and o In 41 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In five out of seven investigations reviewed (71%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The following provides information regarding the concerns identified: o Case #473150 involved the death of an individual. There was a thorough review of documentation in the days before the individual was hospitalized and died. That documentation contained numerous references to a sore on his penis, pressure sores on his buttocks such that he had to remain in bed, positioned to keep his weight off the affected area. Yet in the conclusion, the investigator stated that there were no medical symptoms of illness. While it might have been true that this individual's skin breakdown did not contribute to his death, it was not clear from the report why the investigator concluded that there were no medical symptoms of illness. The investigation would have benefited from an interview of the nurse who was charged with overseeing this individual's health care, and the physician at CCSSLC who provided his primary care. Given that one of the roles of an investigation is to identify ways in which protections, supports, and services need to be improved, the evidence of pressure sores was a significant finding. At a minimum, further investigation or review should have been recommended, even if it was not included as part of the death investigation. o The Unusual Incident investigation of serious injury to Individual #42 also was problematic. This individual broke her ankle when standing up, turning and falling to the floor. The break was not immediately apparent, but when it became swollen and bruised, it was x-rayed and treated medically. The investigation included documentation surrounding the	

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		event, witness statements and video surveillance documentation. It did not, however, include interviews of the nurse who oversaw the individual's health care, or with the physician who treated him. In a case of serious injury, their input on such questions as whether the person suffered from osteoporosis or another medical condition that would explain such a fracture would be important ingredients of a thorough investigation. ▪ The report utilized a standardized format that set forth explicitly and separately: o In seven (100%), each 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 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. A finding of noncompliance has been made. With regard to the DFPS investigations, the issue identified was related to reports not including a description of the results of a review conducted of previous cases involving the alleged perpetrator and/or victim. With regard to the Facility's investigations, issues with regard to the thoroughness of some of the investigations were noted.	
	(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	Based on review of CCSSLC Policy #002.2 and the associated procedure DD.11, it did not require staff supervising the investigations to review each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete and coherent. The policy did not require that any further inquiries or deficiencies be addressed promptly. However, the reporting formats for the Facility unusual incidents investigation reports provided for a signature and comments by the supervisor. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #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.	Noncompliance

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	investigation and/or report shall be addressed promptly.	DFPS Investigations The following summarizes the results of the review of DFPS investigations: ▪ In none of 41 investigation files reviewed (0%) was evidence found that the supervisor had conducted a review of the investigation report. In discussions with the Monitoring Teams, DFPS indicated that supervisors do review all investigations. However the review was being done electronically and no documentation appeared on the investigation report. DFPS has agreed to submit a printout to be included in the Facility's investigation files to indicate they have been reviewed, until they can make a change to their electronic system to allow the supervisory note to appear on the investigation report. At the time of this monitoring review, such documentation was not available for review. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ In five out of seven investigation files reviewed (71%), there was evidence that the supervisor had conducted a review of the investigation report. The Facility POI indicated that a policy was being developed to require supervisory review of all investigations. The POI further indicated that CCSSLC found supervisory signatures or the Director's signature on the five Facility investigations monitored. The Monitoring Team found that only 71% of files had a supervisory signature.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The findings from the Monitoring Team's review of the Facility's investigation of Unusual Incident Reports are discussed in (f) above.	Noncompliance
	(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.	According to CCSSLC Policy #002.2 and procedure #DD.13, disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was to be taken promptly and thoroughly. In addition, the Facility was to have a system for tracking and documenting such actions and the corresponding outcomes. The Facility initially tracked and documented corrective actions for issues identified in the investigation report in Section #21 of the Unusual Incident Investigation report, which was an electronic system. Corrective actions were reported to the Incident Management Committee within 30 days of completion of the investigation. The Incident Management Committee tracked the reports from initiation to completion of the recommendations. In order to determine compliance with this provision of the Settlement Agreement, a	Noncompliance

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		subsample of the investigations included in Sample #D.1 and Sample #D.2, were selected for review. This sub sample, Sample #D.6, included the following investigations: Facility Investigation #461897 and DFPS Investigation #37601781. The Incident Management Team minutes were reviewed to determine if the recommendations were completed. The following summarizes the results of this review: ▪ Investigation #461897 concerned the death of an individual on 8/25/10. The investigation report contained a recommendation that "nursing staff be in-serviced on documenting progress notes in a timely manner and follow the laminated card for 'Documentation Acute and Hospitalization' criteria." The investigation report was completed on 9/1/10, and included the date of 9/15/10 under the column in the report headed "Date completed or target date for completion." The IMT minutes of 8/30/10 recorded the incident. A review of IMT minutes through 9/15/10 did not reveal any further follow-up. ▪ DFPS investigation #37601781 involved misuse of a gait belt on 8/24/10. The recommendation was to in-service staff on their duty to report and on the proper use of the gait belt. On 8/30/10, the IMT referenced the on-going investigation by DFPS. The recommendation appeared in IMT minutes on 9/3/10, and was characterized as a Personal Support Plan Addendum (PSPA) due and Occupational Therapy/Physical Therapy (OT/PT) to complete training on the gait belt. The case was followed in IMT minutes on 9/7/10 through 9/14/10, with no further comment. On 9/15/10, the minutes stopped following the recommendation without comment. It was not possible to determine whether or not the training had taken place from the documentation in the IMT minutes. It is possible that the recommendations in both these cases were carried out. However, it was difficult to follow whether the actions had been taken and what the outcome might have been. The Facility adopted Procedure #DD.18 on 11/5/10 with implementation to begin 12/5/10. It provided instructions for updating recommendations electronically and for maintenance of a monthly tracking binder available to the IMT to track the timely receipt of follow-up documentation on recommendations and action plans. This appeared to be a solution to the tracking issues identified in this report. In many cases, in addition to requiring documentation of completed actions, staff, potentially Investigators should be assigned to confirm the completion of follow-up action. For example, staff training often should result in a quantifiable change in staff behavior, or when physical changes are required in an environment, this could be confirmed. As appropriate, the Facility should physically confirm that changes expected as a result of the implementation of recommendations resulting from investigation reports have occurred.	
	(j) Require that records of the results of every investigation shall be maintained in a	Section DD.5.2 provided a checklist for investigation files maintained by CCSSLC, which was implemented on 12/5/10. Files of the Facility's investigations and the DFPS investigations were maintained in the IMC's office and readily available to permit	Substantial Compliance

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	manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	investigators and other appropriate personnel to easily access every investigation involving a particular individual. The files examined were arranged according to the checklist, which facilitated navigation to documents of particular interest. The Facility investigations were entered electronically into the Facility's computer system, allowing access to investigators without resorting to the paper file. DFPS files were maintained electronically to allow access to their authorized personnel. It appeared that their official reports were transmitted to CCSSLC in hard copy where they were filed.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The CCSSLC Quality Enhancement office tracked and trended unusual incidents and allegations of abuse, neglect and exploitation by: ▪ Type of incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. They do not yet trend staff alleged to have caused the incident. The Facility provided tracking reports for incidents and allegations with analysis in monthly and quarterly trend reports to its QA/QI council and formerly its Performance Improvement Team (PIT). Trend reports were available to Unit teams by unit and by residence. The POI reported that the Facility was developing a review system to address trends through the PIT. This is an essential component to ensuring that incident management information, including information regarding the results of investigations of serious incidents and abuse/neglect/exploitation investigations, is used to improve the system, and to the extent possible, prevent the recurrence of incidents and allegations.	Noncompliance
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	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 a Federal Bureau of Investigation (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-	Substantial Compliance

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	shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	applied for a position also had to undergo these background checks. In concert with the State Office, the Facility 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. This was confirmed in a sample of 20 staff. The information obtained about volunteers was discussed and confirmed with the Facility Director, and confirmed in a sample of the three most recent volunteers. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of October 2010. 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 one person was terminated upon background check information showing a failure to self-report an arrest. 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.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. CCSSLC Policy #002.2 required staff to report unusual incidents within one hour to the Director or designee, but should be revised to provide a clearer explanation of what form the report should take (e.g., phone call, a written report, or whatever was expected.)
2. In addition to increased efforts to remind staff of their responsibilities with regard to the timely reporting of abuse and neglect, ongoing in-service training should focus on delineating the more subtle forms of abuse (such as dragging a person by a gait belt), and reinforcing with staff their responsibilities to report these allegations in addition to more blatant abuse (e.g., hitting an individual).
3. Efforts should be made to ensure that QMRPs discuss and provide the abuse, neglect, and exploitation handouts to individuals at PSP meetings. In addition to reminding, QMRPs about this responsibility, the monitoring tool for PSPs should include an indicator to check to ensure it is done consistently. The provision of this information to the individual should be documented in the PSP.
4. The Facility should continue to strongly train and remind staff, for example, at staff meetings, in newsletters, etc., that retaliation will not be tolerated. In addition, on a case-by-case basis, the Facility should evaluate if actions need to be taken when results of investigations are returned and action is taken, for example, disciplinary action. There might be situations in which based on the results of investigations, and staff's participation in such investigations, and/or due to strained relationships between staff that some staff need to be reassigned to other

units or shifts, or supervision needs to be increased to protect against any possible retaliation. The culture amongst staff of protecting one another as opposed to individuals served can be very strong, and apparently was at Corpus Christi in recent years. Facility management will need to continue to be creative about shifting this culture to one in which the individuals' safety and wellbeing is paramount. Continued focus on instilling the foundational values of protecting individuals who are vulnerable, while at the same time assisting them to enjoy meaningful lives will greatly help in this regard. Any efforts that can be made to reward staff that demonstrate strong values would advance this process.

5. All Facility staff with investigation responsibility should complete required training.
6. The Facility should continue with its efforts to modify its policy to include requirements related to the supervisory review of investigations.
7. In addition to reviewing documents, as appropriate, the Facility should physically confirm that changes expected as a result of the implementation of recommendations resulting from investigation reports have occurred. This may require a change to the Incident Investigation report to add a column under section #21 to show the date the recommendation was completed.
8. The Facility should continue its efforts to finalize a tracking and trending system.
9. The Facility should expand its efforts to conduct critical analysis of the trend data collected to determine if any actions should be taken, or action plans developed to address any underlying causes of trends identified.

The following are offered as additional suggestions to the State and Facility:

1. Consideration should be given to adding a policy/procedure related to the use of video surveillance tapes in investigations.

<table>
<tr><th>SECTION E: Quality Assurance</th><th></th></tr>
<tr><td rowspan="2">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:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o DADS Policy #003: Quality Enhancement, dated 11/13/09;
o CCSSLC Policy #003: Quality Enhancement, dated 11/13/09;
o CCSSLC Procedures E.1 through E.9, revised 12/5/10;
o CCSSLC Plan of Improvement, dated 9/27/10;
o Quality Enhancement Plan FY 2010, undated;
o CCSSLC Quarterly Trending Report from 9/1/10 through 11/20/10 for Injuries, Restraints, Unusual Incidents and Abuse/Neglect/Exploitation, printed 12/21/10;
o Quality Assurance/Quality Improvement (QA/QI) Council minutes, from 9/28/10, 10/5/10, 10/14/10, 10/20/10, 11/2/10, and 11/10/10;
o Program Improvement Team Meeting Minutes, Pacific Unit 10/19/10, Coral Sea Unit 9/20/10, Tropical Unit 10/22/10, and Atlantic Unit 10/21/10;
o CCSS' Advocacy: Shoot the Breeze minutes, dated 8/4/10, 8/11/10, 8/25/10, 9/1/10, 9/8/10, 10/6/10, and 11/17/10;
o Centers for Medicare and Medicaid Services (CMS) Annual Recertification Survey, dated 9/3/10;
o CCSSLC POI Submissions – FY11 for the months of September, October, November, and December 2010;
o CCSSLC Active Treatment Monitoring – Coaching Guide, dated 10/9/10;
o ICF/Regulatory Chart Review, revised 8/5/10;
o Chart Audit Tool, December 2010; and
o Chart Audits, December 2010.
▪ Interviews with:
o Daniel Dickson, Director for Quality Enhancement, on 1/4/11 at 3 p.m.; and
o Program Auditors, on 1/6/11 at 11 a.m.
▪ Observations of:
o Daily Unit Meeting in Atlantic, on 1/4/11 at 10 a.m.; and
o QA/QI Meeting, on 1/6/11 at 1:30 p.m.</td></tr>
<tr><td>Facility Self-Assessment: CCSSLC 's Plan of Improvement had been modified to a simplified format that was easy to follow and contained brief descriptions of the evidence used to self-determine compliance with each element of the Settlement Agreement. The POI was arranged according to the Settlement Agreement sections with an action plan for each section and corresponding reports on progress. As noted in other sections of this report addressing the Facility's self-assessment, many of the sections of the POI, such as the one for Section E, included important narrative information regarding the activities the Facility was undertaking to move toward compliance. As the Facility moves forward in developing its self-assessment processes, in addition to the important narrative information included in the POI, the Facility should include data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance. This data would potentially come from a variety of sources,</td></tr>
</table>

	including, for example, the results of monitoring activities, and outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature. Based on a review of the POI with regard to Section E on Quality Assurance, the Facility found that it remained out of compliance with all five indicators.
	Summary of Monitor's Assessment: CCSSLC had adopted policies and procedures to guide the development of its quality enhancement program. A Quality Enhancement Plan was in place. The plan set out the audit tools to be used for each section of the Settlement Agreement with corresponding expectations for the samples to be drawn, the persons responsible for auditing, reporting, and analyzing the resulting data, and creating corrective action plans. Monitoring tools to measure quality had been adopted based on the tools used by the Settlement Agreement Monitoring Teams, and adapted for use in the Facility. Guidelines for the use of the tools had been written and Quality Monitors were using the tools in the field. Summary reports were available for some of the reviews and were producing raw data. CCSSLC continued to report trend data and analyses on a quarterly schedule for some key issues, such as restraints, abuse allegations, incidents, and injuries. Information was available to show some specific characteristics of incidents, such as where incidents were occurring, what time of day, and on which living units. Breakdowns of data were available by unit and by residence, making it possible for units and residences to use the data as a tool in analyzing and addressing undesirable trends. The Quality Assurance/Quality Improvement Council had been organized to develop, revise, and implement quality assurance procedures. The Performance Implementation Team (PIT) had been reorganized to focus on quality improvements in the units and in service delivery disciplines. The next steps will include competing the Corrective Action Plan process, creating a data system to collect information generated by the monitoring activities, and developing a set of key criteria to measure progress on service outcomes.

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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.	In order for the Facility to be in compliance with this component of the Settlement Agreement, a tracking system needs to be in place to allow identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Although the Facility had begun to collect some data, for example, data related to incidents and allegations, it had not yet developed a set of key indicators. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require	Noncompliance

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		additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, as well as to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a complete system such as this in place, however it did have certain critical elements, including: ▪ Monthly, quarterly, and annual Trend Reports that showed unusual incidents; allegations, investigations, and determinations of abuse, neglect and exploitation, as well as injuries, and restraints; ▪ These reports were displayed by type, individuals involved, location, home hour, shift, day of week, and staff involved. ▪ Independent monitoring compliance data resulting from the implementation of monitoring tools for each section of the Settlement Agreement, such as sampling of PSP records and Incident reports. These had the potential to be used to determine which units were having the most difficulty. In the various sections of this report, the Monitoring Team has provided comments, as appropriate, with regard to the monitoring tools and the Facility's implementation of them; ▪ CCSSLC POI Submissions report, which tracked data on areas of service, including: integrated protections and services, pharmacy services, physical nutritional management, psychological services, and others. It was not clear how this data was generated, but if done correctly, it could form the basis of the key indicators data that is needed to assess performance in areas of care. Two issues discussed with the Director for Quality Enhancement were how to display data involving staff members and how to develop data related to areas of care. The following summarizes the content of these discussions: ▪ Where appropriate, data involving staff members could be displayed according to employee number to assure some anonymity of the staff member. ▪ "Areas of care" referred to in the Settlement Agreement are programmatic and clinical areas such as residential, vocational, medical, psychiatric, nursing, psychology, habilitation therapies, etc. The question is how to collect key indicators of performance in these areas. As mentioned above, the Facility had produced a list of some basic key indicators. Using that as a starting point, the Facility should begin to generate a comprehensive list of key indicators to address the many areas of care outlined in the Settlement Agreement. A poster was in place throughout the Facility that described quality enhancement activities and how they related to the lives of individuals who lived at CCSSLC. This kind of effort is extremely important since the quality of the protections, supports, and services the Facility provides depends heavily on the people who are constantly in direct contact with individuals who live at CCSSLC. They need to know that when they are	

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		filling out forms and charting data that it ultimately helps to improve the supports provided. This type of format would be a good way to display some of the additional key indicator data that the Facility will collect and analyze over time. As noted above, monitoring tools had originally been adopted based on the tools used by the Settlement Agreement Monitoring Teams. Several of these tools, including Restraints, Protection From Harm, and Integrated Supports, had been modified to reflect Facility-specific needs, and to crosswalk them with ICF-MR requirements to avoid having separate and redundant monitoring procedures. The tools now had guidelines to help to assure consistency of monitoring. As noted above, as applicable, the various sections of this report provide commentary on these monitoring tools. Although additional work needs to be done to refine the tools and the processes being used to implement them, progress had been made in this area. The Active Treatment Monitoring – Coaching Guide was a two-page set of questions designed for supervisory staff or Campus Coordinators to ask as they made their rounds of living units. The questions assessed staff's understanding of basic procedures related to the PSP and to the safety of individuals. The form was designed to identify gaps in understanding and to address them immediately through coaching. The purpose of this tool was to teach, not to critique and should remain that way. Based on the Monitoring Team's interactions with direct support professionals as well Campus Coordinators, the use of this coaching guide appeared to be having a positive effect. For example, one of the questions related to how staff greeted visitors to the residences. Consistently, the Monitoring Team noted a professional approach by all staff of welcoming visitors to residences and programs, and asking how they could be of assistance. Anecdotally, staff reported that the individuals CCSSLC supports also had begun to take this approach with visitors. Supervisory staff reported, and the Monitoring Team observed some instances of increased knowledge of the direct support professionals with regard to the specific needs of the individuals they supported. These were all positive outcomes of both the implementation of the guide, but also the increased supervision in the residences. As indicated in the Facility's POI, the Facility was not in substantial compliance on this subsection. However, there was definite progress.	
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	Although the Settlement Agreement did not anticipate full compliance with this provision until 6/26/12, some data were already being analyzed regularly into Trend Reports. For example, data on personal and chemical restraints had been displayed by month and quarter since September 2008. The Facility continued to produce trend reports on restraints, abuse/neglect/ exploitation and injuries. The Quarterly Trend Report for 9/1/10 through 11/30/10	Noncompliance

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	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.	displayed restraint data in two parts: Personal Restraint, including medical and protective restraints, and Total Restraints, including emergency and programmatic. This appeared to be a change from six months ago when restraints were displayed as emergency, programmatic and chemical. The revised format might be a better choice of displays, and it is likely the data can be displayed in any configuration at any time since it is stored electronically. However, it is important that the data be used to show changes over time, and one way to do that is to ensure that the way data is collected and reported is changed through a thoughtful process with clear rationale, and reports include annotations to explain differences. The Quarterly Trend Report examined for this report included good breakdowns of the data: by home, location, day, hour, shift, and cause among other factors. These breakdowns and the associated narrative analysis provided information that could be used to develop systemic strategies for improvements. For example, the report indicated that self-injurious behavior was the most frequent reason for personal restraint with aggression towards staff just slightly less. The report also indicated that the residences where the most restraints were occurring were Apartments #518, #517 and #522C. This report should alert the Restraint Reduction Committee as to where the time and efforts of psychologists and psychiatrists are needed to help understand and reduce restraint use. Another way that the trend analyses could be used productively would be to identify the areas where several issues occur simultaneously, and where concentrated action might produce the largest positive results. At indicated in the Monitoring Team's last report, the data had revealed significant issues with Apartment 511. While there were still issues at that location, it did not rank among the top three in injuries, incidents, or individuals restrained. The Facility reported having taken steps to attempt to address issues identified in this residence, which apparently had resulted in at least limited success. In the last report, the POI reported that the Facility was in the process of developing policies and procedures related to Quality Assurance/Enhancement based on the DADS Policy. The Facility had adopted the DADS policy and revised its E series of procedures to correspond. The procedures were detailed and will require adjustment as practice using them provides lessons on what works best. At the time of the most recent review, the Facility was now using its independent monitoring tools to measure and track the results of monitoring for all sections of the Settlement Agreement and producing data. For example, in November, the Facility had reviewed five incident reports using the monitoring tool. A review of the five incident files were reviewed by the Monitoring Team with essentially the same results the Facility	

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		obtained. Four PSPs in each unit were being monitored monthly, the results tallied and supplied to management for review and follow-up. As all these monitoring tools come into routine use, there will need to be a way to capture, display and analyze the resulting data. In conversation with the Director for Quality Enhancement, it was clear he understood the nature of this issue and was working with DADS staff on solutions. CCSSLC had reorganized the Program Improvement Team (PIT) under Facility Procedure #E.5 into a Quality Assurance/Quality Improvement (QA/QI) Council. Its stated role was to develop, or revise and implement quality assurance procedures "…that detect problems in a timely manner in provision of adequate protections, services and supports and to ensure that appropriate corrective steps are implemented…" Under procedure #E.3 the PIT had been reorganized into unit teams to review data by home and department on a monthly basis, as well as the actions that were planned or being taken to address issues. The PITs and the QA/QI Council had the potential to have the desired positive effect. There needed to be a focus on data review from a variety of sources, but most importantly, a strong commitment to identifying and taking action based on the review of data. Members of the Monitoring Team attended a meeting of the Council on January 6, 2010. The meeting dealt with a number of practical issues that had the potential to impact individuals, such as keeping dental appointments and speeding/parking issues. A number of new or revised policies were reviewed and the team provided constructive feedback on them. There also was a presentation related to the recent revisions to the Observation Notes direct support professionals completed on each shift. This was an excellent example of involving direct support professionals in projects to improve the quality of people's lives and the positive response from staff to being involved in developing or revising procedures and training others. Again, although the Facility remained out of compliance with this requirement much progress had been made. The Facility appeared to have plans to address a number of the areas requiring additional work.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. The POI indicated that the QA/QI Council met in November 2010 to begin developing a draft policy and procedure for developing corrective action plans based on data from the monitoring tools. However, the Monitoring Team noted that there were a variety of action plans attached to different documents. For example, the Action Plans associated with the POI set out specific tasks that needed to be accomplished to bring each section of the Settlement Agreement into substantial compliance. The QA/QI procedures in E.5.2 set out a process	Noncompliance

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		for monthly reporting to the QA/QI Council by department heads on each action plan for which they were responsible. The PIT had a similar procedure. It will be important to find ways to make action plans work to support, but not duplicate the same actions in multiple places. It also is important to note that not every issue requiring corrective action requires an action plan. The Monitoring Panel has discussed this with the State Office. For example, the QA/QI Council might decide that the Facility Director needs to send a memorandum to staff to correct a particular issue. The memo could be sent, and a copy attached to the next set of QA/QI Council minutes with a notation that the corrective action was completed. Likewise, for individual issues, such as modifications needing to be made to an individual's Behavior Support Plan, documentation in the form of a PSPA would be sufficient to document the occurrence of the necessary change. Judgment should be used in deciding which issues require the development and implementation of full corrective action plans, and which issues are more appropriately addressed using another format. This will reduce unnecessary paperwork, while at the same time ensuring that issues that do need formal corrective action plans have them. Although the Monitoring Team identified a number of corrective action plans, as the Facility recognized, there continued to be a number of areas in which data either had not been analyzed adequately to identify the need for corrective action, or a problem had been identified requiring formal attention, but a corrective action plan had not been developed. For example, much of the monitoring data the Facility had collected had not yet been formally analyzed and appropriate corrective action plans developed.	
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.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. As noted above, this procedure was under development by the QA/QI Council. This will be reviewed further during future monitoring visits when additional corrective actions plans are available and being implemented.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. As with Section E.4 of the SA, this will be reviewed during future monitoring visits.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. CCSSLC should continue to revise its monitoring tools to meet the needs of the Facility. If the tools will be scored overall, consideration should be given to weighting the factors that go into producing an overall score. Where guidelines have not been produced for any tools, they should be completed.
2. The Facility should develop and implement a tracking system that allows identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection

and analysis of key indicators or outcome measures. Throughout this report, there are references made to data that should be incorporated into such a system. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system.

3. The Facility should resolve its issue over how to display data related to staff.
4. When the data displays or collection methods change, the Facility should annotate documents such as trend reports. This will ensure that data is comparable over time and that it will be possible to identify progress.
5. As problematic trends and/or individual issues are identified, the Facility should develop, implement and monitor corrective action plans.
6. The Facility should continue use of the Active Treatment Monitoring – Coaching Guide, and, particularly, to continue to use it as a positive (as opposed to punitive) tool to effectuate for change at the programmatic level.
7. As the Facility moves forward in developing its self-assessment processes, in addition to the important narrative information included in the POI, the Facility should include data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance. This data would potentially come from a variety of sources, including, for example, the results of monitoring activities, and outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature. This data should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section F; o CCSSLC Policy #004; dated 7/30/10; o CCSSLC Policy Sections F – F.16, updated 12/5/10; o CCSSLC Active Treatment Monitoring – Coaching Guide, dated 10/9/10; o QMRP Check Sheet for Personal Support Plan Process, dated 7/23/10; o Supporting Visions: Personal Support Planning, dated July 2010 o Personal Focus Assessment (PFA) form, dated 9/10/10; o List of Individuals with most recent PSP date, and previous date; o Sample of monthly record/PSP audits and compilation tracking log; and o Personal Support Plans (PSPs), Sign-in Sheets, Assessments, Personal Support Plan Addenda, (PSPAs), Personal Focus Assessments (PFAs), Positive Adaptive Living Skills Assessments (PALS), any staff training on PSPs, and any monthly and/or quarterly reviews for the following individuals: Individual #4, Individual #313, Individual #329, Individual #286, Individual #327, Individual #251, Individual #190, Individual #246, Individual #377, Individual #62, Individual #307, Individual #25, Individual #36, Individual #101, Individual #278, Individual #47, Individual #230, Individual #349, Individual #194, and Individual #333. ▪ **Interviews with**: o Daniel Dickson, Director of Quality Enhancement; o Rachel Rodriguez, QMRP Coordinator; o Bruce Boswell, Programs Director; o Program monitors; o Various QMRPs; o Individual; and o Various staff at apartments 522A, 522B, 522C, 522D, 515, 516, 511, 514 and 517 and Vocational Building 513. ▪ **Observations of**: o PSP meetings for Individual #298 and Individual #126.
	Facility Self-Assessment: Based on a review of the Facility's POI with regard to Section F of the Settlement Agreement, the Facility found that it remained out of compliance on all of the indicators, although progress was noted on most. In addition, the POI included action steps on selected outcomes resulting from the Monitoring Team's last report. Outcomes included policy development, training of QMRPs on the new PSP process, and training of team members on the new process all of which were reported to have been completed or on target. Specific data was reported for some of the indicators for example:

	▪ On Section F.2.a.1 the Facility reported that since July 2010, 13 individuals had been referred for alternate placement and six of the 13 were placed in group homes; ▪ On Section F.2.a.1 the Facility reported that 49 (17%) of the PSP meetings had been held using the new PSP format. This kind of concrete and verifiable data is useful in evaluating performance, and should be expanded upon in future self-assessments. The Facility's progress in developing a quality assurance process for Section F is discussed in further detail below with regard to Section F.2.g.
	Summary of Monitor's Assessment: The Facility had adopted the State PSP policy, and developed corresponding Facility policies and procedures. The Personal Support Plan Process policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the use of the Personal Focus Assessment, and required assessments and those to be determined by the PFA. The policy addressed PSP monitoring, staff training and quality assurance. Where it fell short was in describing how to design Action Plans, Skill Acquisition Plans and Service Objectives so that they reflected the interdisciplinary coordination that is required. All QMRPs had gone through initial training on the new process. Some of the PSP meetings the Monitoring Team observed showed improved facilitation skills, and a person centered focus. Improvement had begun to be seen in the area of identifying preferences of individuals. Incorporation of these preferences into the overall PSP continued to need work. Some additional areas that required attention included: ▪ As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning; ▪ Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen; and ▪ The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two	DADS Policy #004 Personal Support Plan Process was issued on 7/30/10. It was adopted as CCSSLC Policy #004 and CCSSLC Procedure Sections F through F.16, dated 12/5/10. The Personal Support Plan Process policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the	Noncompliance

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	years, the IDT for each individual shall:	use of the Personal Focus Assessment, and required assessments and those to be determined by the PFA. The policy addressed PSP monitoring, staff training and quality assurance. Where it fell short was it describing how to design Action Plans, Skill Acquisition Plans and Service Objectives so that they reflected the interdisciplinary coordination that is required. The 20 PSPs that were reviewed were chosen from among the list of individuals for whom the new format/process for PSPs had been used. The sample was selected randomly, and included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans.	
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.	DADS Policy #004 at II.C.1.b indicated that the QMRP would plan and facilitate the PSP meeting. The QMRP Coordinator confirmed that QMRPs facilitated the teams, including team meetings. Reviews of PSPs also suggested that the QMRP was the team leader and responsible for ensuring team participation. Progress had been made in this area in that the new DADS policy was in place, and key Facility staff had completed initial training. Specifically, all QMRPs at CCSSLC had undergone the initial training on the new PSP process and format. This policy clearly identified QMRPs as responsible for facilitating the teams. However, based on review of PSPs as well as during observation of three meetings held the week of the on-site review, facilitation of team meetings was not consistently resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. This is a key requirement to achieve compliance with this component of the Settlement Agreement. Based on observations while the Monitoring Team was onsite the annual planning meetings for Individual #298 and Individual #126 indicated that the QMRP was facilitating the meeting. In both case the QMRP spoke first with the individual to make sure he/she knew what the meeting was about and was comfortable with the people present. Unlike similar meetings on prior visits, this time the QMRP elicited discussion from team members and encouraged participation while remaining focused on the needs and interests of the individual. The QMRPs in both meetings used checklists to help them guide the meeting and to assure all necessary tasks were completed. These meetings had improved over past meetings in their focus on the individual and engagement in problem solving that occurred. However, the meeting for Individual #338 was not as successful. Opportunities for team members to collaborate to develop integrated plans were lost. For example, the at-risk discussion did not result in appropriate assessment of risk areas, or plans to address them. For such positive changes to continue, training in meeting	Noncompliance

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		facilitation will need to be available to QMRPs. An important change was related to QMRP staffing. At the time of the baseline review, it was reported that the average caseload was one QMRP to 24 individuals. Since then, approximately four QMRPs had been hired, increasing the number of QMRPs to 18. This reduced the average caseload to 1:15 to 1:18. In addition, some of the duties of the QMRPs were being shifted. For example, Active Treatment Coordinators had been assigned responsibility for drafting skill acquisition programs. These changes should assist QMRPs in being able to complete the many requirements of their job, including the adequate facilitation of PSP meetings. Since the beginning of December 2010, the supervision for QMRPs had been shifted from the Unit Directors to the QMRP Coordinator. Although this was a positive change, the QMRP Coordinator had an extremely large span of control given that she was responsible for supervising 18 QMRPs. She indicated that she had spoken with the Facility Director about the possibility of hiring a QMRP Educator who could assist with some of her duties. Another option being considered was having some QMRPs as lead staff. The QMRP Coordinator had begun attending many PSP meetings to allow immediate support and coaching on the new PSP process. She identified the biggest training need for QMRPs as team facilitation. Other areas in which the QMRP Coordinator recognized additional work was needed was with regard to documenting team discussion, and improving the action plans in PSPs to include more than skill acquisition objectives. This was consistent with the Monitoring Team's findings. Based on observations as well as review of PSPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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	DADS Policy #004 described the Personal Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QMRP, direct support professionals, and persons identified in the Personal Focus Meeting as appropriate, as well as professionals dictated by the individual's strengths, needs, and preferences. Based on interview with staff, the Facility was in the process developing a database to track attendance at PSP meetings. The Information Technology Department had created a database, and information was being entered into it. The database included the date and time of the meeting, and using the PFA, those who needed to be in attendance at the meeting would be identified. The database would track actual attendance as well.	Noncompliance

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	individual's preferences and needs.	In reviewing PSP sign-in sheets, QMRPs were present at the annual meetings, and the individual almost always was present. Others participating included, at times, nurses, direct support professionals, Legally Authorized Representatives, psychologists, Occupational Therapists (OTs), Physical Therapists (PTs), Speech Language Pathologists (SLPs), and other disciplines, depending on the individual's circumstances. Physicians rarely attended. Often, neither an OT nor PT attended, even in situations in which an individual had OT/PT needs. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. In none of a subsample of 14 PSPs reviewed (0%) did it appear that a duly-constituted team attended. For example: ▪ Individual #101 had a PNMP, including a positioning plan, and transfer, bathing, and handling instructions, and she had a gastrostomy tube (g-tube) for enteral nutrition. Neither an Occupational Therapist nor Physical Therapist was present at her annual PSP meeting. ▪ Individual #36's PSP indicated that he "had significant medical issues that require 24 hour nursing. He has a high risk of respiratory compromise due to chronic lung disease… His declining health is another obstacle." However, no physician was present at his PSP meeting. Likewise, he has a PNMP and extensive needs related to adaptive equipment, but no Physical Therapist was present at his meeting. ▪ Individual #25 had a PNMP to address multiple physical and nutritional management needs, but no Occupational Therapist, Physical Therapist, or Speech Language Pathologist was present. In addition, no physician participated in the annual PSP meeting for Individual #25. ▪ Individual #327 had a number of medical complexities, including a number of factors that placed her at high risk. Based on her PSP, "During her Health Status discussion, it was determined [Individual #327] has a high risk for Aspiration, fluid volume deficit, nutrition altered, less than body requirements (sic) and infection." She had a PNMP. Her physician, Occupational Therapist, Physical Therapist, Speech Language Pathologist, and Dietician did not attend her annual PSP meeting.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	Most of the PSPs reviewed included assessments related to residential living [often portions of the Positive Adaptive Living Skills (PALS)], nursing, behavior including psychological evaluations, speech, OT/PT, nutrition, self-administration of medication, audiological screening, dental, and other assessments based on specific needs. Vocational assessments were in some files. Plans included a Personal Focus Assessment that gathered information on the individual's preferences. Some of the PFAs identified the assessments that the team decided needed to be completed. Some plans included the	Noncompliance

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		DADS-issued assessment forms for various potential risks such as aspiration, weight, nursing risks, and polypharmacy, but in this sample there appeared few references to risk assessment. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. This is discussed in further details throughout this report with regard to the sections of the Settlement Agreement that address psychiatric services (Section J), psychology (Section K), medical services (Section L), nursing services (Section M), physical and nutritional supports and OT/PT (Sections O and P), communication (Section R), and habilitation and skill acquisition (Section S). In order for adequate protections, supports and services to be included in individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. In two of 20 (10%) PSP files reviewed, adequate assessments were present. Often the narrative sections of individuals' PSPs identified issues of concerns for which assessments were not found. This was often the case with regard to individuals' medical and psychiatric needs, for which updated assessments did not appear to be available to the team at the time of the PSP meeting. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. The following provide examples of PSPs in which concerns were noted: ▪ As noted above, Individual #36 was described as having complex medical needs and declining health. His PFA did not indicate that a medical assessment was needed, and no medical assessment was included in the package of assessments submitted with his PSP. ▪ Individual #307's team had met to conduct the Personal Focus Assessment. Although the team identified the need for the following assessments, they were not included in the package of assessments used to develop the PSP: medical assessment, psychological assessment, and rights assessment. ▪ Individual #62's PSP indicated that he had poor attendance at work. He worked at the Annex on the hangers and rags jobs. At his Personal Focus Assessment meeting, he indicated that he would like to work for a cell phone company. Prior to the PFA meeting, a vocational assessment was completed. It was unclear from the assessment what methodologies were used to complete it. For example, the assessment did not indicate if the assessor used interviews with the individual and/or staff who had worked with him, observations, record review, formal testing, and/or situational assessments to gather the information used in the report. The assessment included summary statements regarding Individual #62's Vocational/Employment Vision, Obstacles to Employment Vision, and Work Preferences. However, because the methodology used was not clear, it was difficult to determine if the conclusions	

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		drawn were accurate and/or comprehensive. For example, the Vocational/Employment Vision indicated that: "[Individual #62's] vision is to continue working to make money to pay for his cell phone and buy his game electronics. He would like to move out of the state school and work indoors being an office assistant." It was uncertain if this vision was based on Individual #62's limited exposure to jobs that might be available, or if situational assessments had been utilized to provide Individual #62 with some experience with different types of jobs that might be available to him. The Preferences section provided a little more information about the nature of work the assessor had determined Individual #62 might be successful doing, including working in a small work setting, with moderate supervision, and a part-time job that was moderately physical in nature. Again, it was not clear what methodologies were used to draw these conclusions. The only obstacle listed for attaining his employment vision was "Lack of motivation." No information was provided about what motivated Individual #62, or how these motivating factors might be used to increase his participation in work. There was no evidence that his team discussed this further at his PSP meeting. It did not appear that the assessor or team had given any consideration to whether the lack of motivation was in relation to the specific job options that had been made available to Individual #62. Moreover, the only recommendation included in the Vocational Assessment was: "[Individual #62] will count hangers in increments of 300 and place them on the rack with the correct label." The team did not include this objective in his PSP, and, in fact, the PSP included vocational objectives that bore no relationship with the findings of the Vocational Assessment. The team included in the PSP objectives related to learning how to dress when going to work, proper hygiene for work, and learning that each job required different clothing. These were not areas that had been identified in the Vocational Assessment as problematic. In summary, Individual #62's vocational assessment did not provide his team with a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history, or interest inventory. This limited the team's ability to develop a plan to assist Individual #62 to reach his employment goals. ▪ Likewise, Individual #251's vocational assessment did not represent a vocational profile based on objective data, situational assessments, and/or a thorough work history, or interest inventory. As a result, it did not provide her team with an adequate vision of the type of employment that should be sought for her. For example, her Vocational Employment Vision stated: "[Individual #251's] vision is to live closer to her family in… Texas and be able to continue working at a similar job like she is doing here (working assembly – paper shredding/cleaning) and make money to buy her hair products." The only	

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		recommendation included in the Vocational Assessment was for the following skill acquisition plan: "[Individual #251] will work on weighing her own paper to shred in increments of 2 lbs using the electric scale." Part of the assessment listed previous work history. The only items checked were paper cleaning and paper shredding. This was an indication that Individual #251 had extremely limited exposure to potential jobs. Situational assessments would have been an appropriate option for allowing her to determine where her employment interests lay, as well as an opportunity for the assessor to better evaluate her skills in various areas. Although the vocational assessment identified many positive work habits and employment characteristics, the resulting recommendation did not lead the team to consider other vocational opportunities or training for Individual #251. One assessment that would prove useful for some individuals would be an annual review of incidents, and A/N/E allegations. This type of assessment was not found in any of the PSPs reviewed. However, for some individuals, it would be beneficial on an annual basis for teams to review aggregate individual data related to incidents, allegations, and restraints. This would ensure that the team considered the need to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. The intent of such a review would be to ensure that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the PSP. Overall, assessments were either not present or inadequate to guide teams properly in developing adequate PSPs. This is an area that will require the concerted efforts of all team members to resolve.	
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.	Although the new PSP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continue to need to incorporate thoroughly the results of assessments in the PSPs. Based on the review of the 20 plans, even when assessments were present, the connection between the assessment results and the PSP were not always clear. In none of the 20 plans (0%) were all recommendations resulting from assessments addressed in the PSPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. For example: ▪ Individual #307's PSP did not address many of the recommendations included in the assessments provided to the team, and there was not justification included in the plan for not addressing these recommendations. For example, the dietary/nutritional assessment included a number of recommendations that the PSP did not address. Likewise, the OT/PT assessment indicated that staff should continue to provide Individual #307 with therapeutic positioning according to	Noncompliance

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		her PNMP, and continue the current diet. Neither of these recommendations were reflected in the action plans of the PSP. ▪ Individual #62's Health Risk Assessment Rating Tool indicated he was at high risk due to weight loss. There was no mention of this in his PSP, and no plan to address it. Likewise, his nutritional evaluation made recommendations to promote weight gain, but these were not included in his PSP. In addition, although the narrative section of Individual #62's PSP made reference to a BSP, it was not integrated into the PSP's action plans. ▪ Individual #251's Psychological Update included a number of recommendations that were not specifically integrated into the PSP. Likewise, the Dietician had made a number of recommendations in her assessment, but it did not appear these had been integrated into the PSP, nor had the team discussed them and provided justification for not including them. For example, one recommendation was to "encourage regular physical activity as tolerated via work or scheduled exercise program." No exercise program was included in the PSP. Individual #251 was considered overweight, and was on a restricted calorie diet. An exercise program would have been an important support to assist her in remaining healthy, but also to potentially reduce a rights restriction. The State and the Facility should ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Person-centered planning is not a reason for not having plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences, strengths, etc. In addition, there appeared to be two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a PSP that outlined the protections, services and supports provided to the individual. These were: 1) based on observations and review of documentation in PSPs, there was a lack of consistent interdisciplinary discussion and coordination in the development of PSPs. This limited teams' ability to utilize assessment information to develop integrated protections, supports, and services; and 2) as is noted in other sections of this report, many of the assessments and evaluations being conducted were inadequate. Examples of this include inadequate nursing assessments, vocational assessments, psychiatric assessments, and assessments of individuals' physical and nutritional management support needs. The Facility needs to address these two issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the SA.	

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F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	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.	Noncompliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The 20 newer PSPs reviewed generally included more information regarding the individual's preferences and strengths. Documentation showed that the teams utilized information gained about individuals' preferences at the Personal Focus Assessment meetings that were held in the month preceding the annual PSP meeting to focus the initial discussion of the team during the PSP meeting. However, many of these preferences related to "maintaining good health" or the recreational interests of the individuals. They were not necessarily comprehensive in nature, indicating individuals' specific preferences related to living environments or jobs. Moreover, some teams had clearly included preferences in the PSPs, but it often was difficult to determine how the identified preferences of the individuals were incorporated throughout their PSPs. Examples of where individuals' preferences had been specifically integrated into Individual's PSPs included: ▪ Individual #190's plan showed integration of preferences into skill acquisition goals, particularly her preference for access to Braille items that had been integrated with her money management goal, and community activities. However, her objective related to community integration only occurred once a month. It was unclear why this was not a more frequent occurrence if it was a clear preference. Examples of where it was less clear how individuals' preferences were incorporated into	Noncompliance

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		their PSPs included: ▪ Individual #251 had listed a number of preferences that mostly related to recreational activities, it was unclear how the team had integrated these preferences with the supports she was being provided. As is discussed in greater detail above with regard to Section F.1.c, her vocational assessment did not clearly identify her preferences related to work, and her team had not elicited this information as part of the PFA process. In addition, the plans were beginning to document some discussion regarding the prioritization of individuals' needs for protections, supports, and services. These were general in nature, though. For example priorities were listed as "daily living skills" or "medical supports." Clear prioritization of the individual's specific needs (e.g., one daily living skill as opposed to another, or which specific medical supports took priority over other needs or preferences, etc.), or careful delineation of barriers to addressing needs was generally not found. The integration of individuals' preferences to address needs or barriers also was not consistently seen. It was not consistently clear whether or how the goals and objectives were related to individuals' preferences, or were designed to overcome barriers to living in the most integrated setting. It is positive that preferences and strengths were being identified and incorporated into plans in some fashion, but more work will need to be done to integrate the individuals' preferences and strengths into the overall delivery of supports and services. Some examples of concerns noted with the 20 newer plans included: ▪ Individual #25's team had identified a number of his preferences, including strong relationships with his family, exposure to off campus events, and personal attention from staff. In the narrative section of the PSP, the team had identified some specific community outings in which Individual #25 might like to participate, including going to the aquarium, car races, or a concert at a local park. None of the specific preferences the team identified were incorporated into the PSP. For example, the PSP noted that contact with his family had gone from several times a year in recent years to none during the past year. No discussion or action plans were included in the PSP related to assisting Individual #25 to reestablish contact with his family. A general action plan included twice weekly trips out of his home on campus, including visits to the community, but none of the specific activities listed as preferences in the narrative portion of the PSP were integrated into the action plan. ▪ Individual #307's team had conducted assessments using a number of the PALS subcomponents. This assessment had revealed a number of areas of need. No information was provided with regard to how the team decided what the prioritized needs were for Individual #307's skill acquisition objectives. She had training objectives to count three Digital Video Discs, wipe down her upper	

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		chest, brush her teeth, and drop the bath towel into the hamper. The discussion record did not indicate how or if these were related to her preferences or strengths, or why they were selected over other needs identified in the assessment. In reviewing objectives related to individuals' involvement in the community, they often were general community participation objectives as opposed to skill building objectives to assist individuals in accessing and utilizing community offerings. Some PSPs reviewed included no objectives related to community involvement. For example: ▪ Individual #36's PSP included no objectives related to community involvement. His PFA had identified the possibility of his attending a sporting event in the community, because this appeared to be one of his preferred activities. Although his preference for sporting events was listed, no objective for linking this with a community integration activity was included. ▪ On a positive note, Individual #251's PSP included an objective for her to "be provided transportation to and from community integration activities" at least three time as week or more. She also had objectives to look up movie show times, which could be accomplished by looking in a newspaper, on the internet, or by calling a movie theater. She also had an objective for direct support professionals to "Continue to educate [Individual #251] on the Care B [bus] line." However, it did not appear that this meant actually taking the bus. Given that Individual #251 was being supported to frequently access the community, it would have been beneficial to include more skill building objectives that were taught in the community. For example, she had a money management goal to identify a nickel. This was being done at the Facility. Consideration should be given to incorporating these types of objectives into community integration activities to provide individuals with more opportunities to practice using these skills in real world situations. As is discussed below with regard to Section S.3.b, the Facility was making efforts to include objectives that encouraged community participation. At the time of the review, approximately 13 percent of the individuals at CCSSLC had goal/objectives that specifically were to be implemented in community settings. Additional work was being done to overcome some of the barriers to this. Although the Facility had made progress, it will continue to be a challenge to address barriers such as transportation, payment of staff's expenses when supporting individuals to participate in recreational and food-related activities, and ensuring adequate staffing is available for individuals to participate in community activities in small groups.	
	2. Specifies individualized, observable and/or	As noted in the last monitoring report, PSPs generally included some individualized and measurable goals/objectives, treatment strategies and supports. However, in most of the	Noncompliance

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	measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	plans reviewed, the expected outcomes were general and not measurable. In a number of cases, individualized, observable and/or measurable objectives had not been delineated in the PSP, and/or the treatments or strategies to be employed or necessary supports were not stated specifically. For example: ▪ Individual #101 had a PNMP that identified a number of strategies related to positioning, bathing, handling, transferring, and receiving nutrition through her g-tube. No measurable, functional outcomes were connected to this plan or included in her PSP. The action plan for the PNMP only listed the OT/PT/SLP as responsible, and indicated that the therapists would complete monthly reviews. It was not clear what the role of direct support professionals was expected to be, or what data would be collected to determine if the plan was effective. Similarly, Individual #101's nursing care plans included some measurable objectives. However, these objectives were not incorporated/integrated into the PSP. Rather, there was merely a reference to the plans. The nursing care plans included some requirements for in-service training of direct support professionals. These requirements were not included in the PSP at all, but should have been included as measurable service objectives. ▪ Individual #307 had a PNMP, a number of health care plans, and a BSP. All of these were referenced in the narrative section of the plan. The health care plans were referenced in an action plan that merely stated they should be implemented. None of these plans were integrated into the PSP through the inclusion of specific, measurable goals and objectives. Specific outcomes related to these plans were not identified. The PSP should be the one comprehensive document that identifies all of the protection, supports, and services the individual needs to meet his/her needs and attain clearly identified outcomes. As is discussed in further detail throughout this report, improvement was needed in this area. For example, nursing plans, which should have been incorporated into the overall PSP, did not generally contain individualized measurable goals/objectives. This is further detailed in the section of this report that addresses Section M of the Settlement Agreement. Likewise, as is discussed below with regard to Sections O and P of the SA, measurable functional outcomes were not being identified for individuals in need of physical and nutritional supports. At this juncture, behavior support plans and psychiatric treatment plans did not contain all of the measurable goals and/or objectives that they should. In the section below that addresses Section T.1.b.1, 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. In summary, the Facility is at the very initial stages of complying with this component of the SA.3	

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	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	PSPs appeared to integrate some, but not all protections, services and supports that individuals required. For example, the health services portion of the plan, similar to the PBSP and PNMP, frequently still were separate plans that were not integrated in any measurable way into the PSP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Examples of issues related to the lack of integration were found between nursing and physical and nutritional supports to incorporate PNMPs with dental care, and dental and psychology to develop and implement desensitization plans. All of these are examples of coordination and integration that should be occurring as part of the individual planning process. For example: ▪ As noted above, Individual #101 had a PNMP and nursing care plans. Although referenced in the PSP, they were not integrated into the PSP through the inclusion of measurable objectives/outcomes. In addition, although the nursing assessment identified aspiration as a risk related to Gastroesophageal Reflux Disease (GERD), it did not appear that nursing had integrated the strategies included on the PNMP into its health management plan for G-tube Feeding, Hydration or Medications. ▪ Individual #307's PSP made reference to a BSP that addressed pica. She also had a PNMP that referenced her diagnosis of pica, and a nursing care plan for pica. There was no evidence in the PSP that the team had ensured that these plans were integrated with one another, and were consistent in their approaches to pica. For example, the PSP indicated she had several instances of eating paper over the past year. No discussion was documented between disciplines and other team members regarding strategies to reduce this behavior, or progress based on data collected on the various plans' implementation. ▪ Individual #246 had a PNMP as well as a BSP. The PNMP did not include any measurable functional outcomes or objectives. Moreover, its implementation was not incorporated in any way into the action plans included in the PSP. The BSP included some objectives, but these were not integrated into the action plans in the PSP. In addition, there were issues raised in the discussion record of the PSP that should have resulted in integrated discussion and planning, but based on the documentation, this did not occur. For example, Individual #246 had missed 10 dental appointments due to refusals. This should have resulted in a number of members of his team brainstorming to identify strategies that could be used to improve this outcome (e.g., psychology, dental, nursing, direct support professionals, etc.). No action plan to address these refusals was included in his PSP. Likewise, Individual #246 was eating too fast, and according to an addendum to his PSP had one-to-one staffing during mealtimes to reduce his risk in this area. Based on the documentation provided, it did not appear that adequate integrated planning had occurred to consider and implement other options designed to reduce the need for this restrictive level of programming.	Noncompliance

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		Again, this would be an example of where psychology staff should have worked with other disciplines to develop strategies to assist Individual #246 in being able to eat safely and independently. From limited information provided, it appeared, for example, that environmental factors might be playing a role. Individual #246 had stated he did not like others watching him eat. ▪ Individual #251 had a BSP that was referenced in the narrative section of the PSP. On a positive note, one of the action plan steps indicated that Individual #251 "will continue to work on replacement behaviors." However, this was not a measurable action step. Moreover, the PSP did not include action steps incorporating the objectives related to reducing target behaviors included in the BSP or require overall implementation of the BSP. Individual had a PNMP. It was not integrated fully into the PSP through specific action plans. It should be noted that the PNMP did not include measurable outcomes or objectives that would have facilitated its inclusion into the PSP.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Generally, for the action items identified by teams, methods, timeframes and staff responsible were identified. However, adequate methods for implementation were not always adequate as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As identified in other sections of this report, not all of the interventions, strategies and supports offered to individuals at CCSSLC effectively addressed individuals' needs, and not all were practical and functional at the Facility and/or in community settings. Again, these are discussed with regard to the need for improvements with regard to plans to address conditions that place individuals' at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and Positive Behavior Support Plans. Examples of PSPs that did not effectively address individuals' needs, and/or were not practical and functional at the Facility and/or in community settings included: ▪ Individual #36 was described as having multiple medical issues, including a number of risk factors. For example, he was identified as being at high risk for respiratory compromise, and medium risk for choking, aspiration, cardiac disease, gastrointestinal problems, seizures, urinary tract infections, and skin integrity. Although the risk assessment form listed some of the actions being taken to address these health concerns, neither it nor the PSP document set forth a comprehensive plan to address the areas of risk, including interventions, supports and services, as well as measurable outcomes/indicators to determine the efficacy of the plan's implementation. It should be noted that it is unclear why he was identified as medium risk for aspiration, because he had been hospitalized three times for pneumonia over the last year, was fed enterally, and had a diagnosis of GERD.	Noncompliance

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		▪ Individual #47 had assessments indicating he had been experiencing falls, with no clear explanation of the reason for the falls. Provision was made for a floor mat to protect him during falls and he had an action plan to help him walk more slowly, although it was not clear that his pace was causing the falls. ▪ Individual #230 was described as a capable woman who liked to look nice and had good on-the-job behavior at her worksite. She was reported to take her dentures out to eat, causing problems with safe swallowing. However, her PSP did not include an action plan to investigate why she would not use her dentures to eat, whether the dentures needed refitting, and/or whether she needed some training on using them. The connection to her appearance was not made at all.	
	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.	Generally, PSPs and the resulting Specific Program Objectives contained data collection methods, frequency with which data should be collected, and identified a person(s) responsible. However, again, as is discussed in other sections of this report, not all components of individuals' PSPs identified the data to be collected, the frequency, and/or the persons responsible for such data collection. For example, some of these elements were missing from the nursing care plans, as well as psychiatric services, such as the monitoring of symptoms that medications were prescribed to reduce. Examples of this from the 20 plans reviewed included: ▪ Individual #101's PSP included no objectives related to implementation of her PNMP or health care/nursing plans. Although her health care/nursing plans included some measurable objectives, the PSP did not incorporate these, nor was the data to be collected delineated, person's responsible for data collection (e.g., direct support professionals for issues such as constipation, seizures, etc.), or people responsible for data review. ▪ Likewise, Individual #36's PSP included no objectives related to the implementation of his PNMP or health care/nursing plans. He had complex needs that required numerous interventions and monitoring by staff on a daily basis. Just a few examples of this included daily monitoring of his temperature, implementation of a positioning plan, and monitoring for skin integrity. The PSP did not include any indication that data was to be collected related to these specific supports. It made vague reference to implementation of the health management plans. They were not submitted for review, so it could not be determined if they included measurable objectives or outcome measures against which efficacy of the plans could be measured. If they did, these objectives should have been incorporated into the PSP. ▪ Individual #327 was identified at high risk in a number of areas, including aspiration, altered nutrition, and infection. She had a PNMP as well as a number of health care plans. Although these were mentioned in the narrative section of the PSP, they were not incorporated into the action plan section of the PSP. No measurable objectives were identified to monitor the efficacy of these plans.	Noncompliance

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		Generally, none of the 20 PSPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. For example: ▪ Individual #307's plan referenced a behavior support plan for pica. She also had a health care plan and PNMP that addressed pica. There was no discussion about progress she had made or the lack thereof on decreasing pica or increasing replacement behaviors. Without this discussion, it was unclear how the team made decisions to continue or revise these plans. Unfortunately, none of these plans were adequately incorporated into the most recent PSP, and the PSP included no measurable objectives related to any of these plans by which to measure their efficacy. ▪ Individual #246 had a number of plans in place, including a BSP, PNMP, and a number of skill acquisition plans. Based on the documentation included in his annual PSP, the team discussion did not incorporate the actual data related to these plans. Rather, there were comments included such as: "He is making progress on his SPO [Specific Program Objective] by attending work tow (sic) or more times a week." The team should rely on data when making decisions about the continuation or need to modify existing plans. In addition, even when data was discussed, such as Individual #246 refusing 10 dental appointments within the last year, the team did not respond by developing a plan to address this issue.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted above, there were issues with regard to the integration and coordination of outcomes, services and supports in individuals' PSPs. This will continue to be evaluated as the new policy and format for PSPs is implemented.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	At the time of the review, the PSP was located on the residential unit, but locked in a cabinet for security reasons. Given privacy and security requirements, this was appropriate. It appeared that if staff needed access to the locked records, a key was easily available. The SPOs were located on the unit and accessible to staff, usually in folders or notebooks. One of the concerns related to the ability of staff responsible for implementing PSPs to understand them was the use of professional jargon that was not defined in the plans. It is inevitable that PSPs will need to include medical and other clinical terms that all team members responsible for the implementation of the plan might not understand.	Noncompliance

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		However, it is important for these terms to be defined. The following provide examples of jargon that was used that was likely difficult for all team members to understand: ▪ The medical section of Individual #36's PSP included the following: "he requires the use of a chest vest at 12 Hz and pressure of 2 x 20 min bid; O2 @ 2 liters nasal cannula via concentrator to keep O2 stats above 92%... receives 2 cal HN 160 mls pgt bolus qid… CHF is maintained with medication… Cardiomegaly with Mitral Valve prolapse andn (sic) Regurgitation and requires SBE prophylaxis for invasive procedures…" The action plan to assist him to "maintain improved health" included very few measurable steps, but one for which the "DCP" or direct care professionals were responsible read: "Myoclonic jerk movements." It was unclear what this meant. Given the brevity of the action plans related to Individual #36's PSP and the extensive medical jargon in the medical section of the PSP, it was difficult to determine who was supposed to provide which supports and services to him when. Another issue related to comprehensibility of the 20 PSPs reviewed was the lack of delineation of responsibility for the implementation of the plans. As a direct support professional, it would be difficult to read the PSPs as written and determine what his/her responsibilities were for the individual during the course of the 24-hour day. This in large part was due to the fact that the PSPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., BSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall PSP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as	Based on interviews with Facility staff, monthly reviews were not being completed consistently. This was confirmed through document review. Based on review of the 20 newer PSPs, 13 had been completed sufficiently prior to the Monitoring Team's review to require at least one monthly review. Of these 13, one (8%) had documentation to show that timely monthly reviews had been completed. There were three (27%) for whom reviews had been conducted, but the reviews were overdue by many weeks. Even for those individuals for whom monthly reviews had been conducted, this was not consistently a full review of each program or support. For example: ▪ A monthly review had been completed for Individual #62 whose PSP meeting had been held in November 2010. The PSP had not incorporated objectives related to his BSP. Although a BSP was being implemented for Individual #62, the monthly review did not include a review of this data. It only included a	Noncompliance

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	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.	review of the skill acquisition goals that had been delineated in the PSP. ▪ Individual #313's monthly review, on the other hand, only included review of behavioral data, not of the skill acquisition plans or other programs referenced in the PSP. Of these none showed that the team had identified a need for changes to be made to the plan.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	Supporting Visions: Personal Support Planning, July 2010 was the new training curriculum for personal supports planning. The document designated this training as competency-based relying on two aspects of the materials, including that the learning objectives were derived by examining what employees needed to know and be able to do on the job, and that practice events in the instruction curricula related to selected learning objectives. The criteria for receiving credit for the course were attendance, participation in competency-based activity, and assessment throughout the course. This training did not meet the requirements for competency-based training. In order to meet the Settlement Agreement requirements with regard to competency-based training, QMRPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. The course contained a variety of activities including role-playing, paper and pencil self-assessments and videotaped demonstrations. A workbook was included so that learners could have a visual prompt and set of activities at hand. The training instructors had special training in presenting this course and were certified to do this training. Training rosters presented to the monitoring team indicated that over 500 people had been trained and according to discussion with the QMRP Coordinator, all those who participated as team members had received the four-hour training. An abbreviated version of the training was scheduled for the rest of the staff at CCSSLC. This training course provided a good introduction to the development of PSPs, the differences between the new and the old processes, the roles of team members and the expectations for individualized and integrated plans. The training explained the "why" behind the changes, but not the" how." There will need to be additional teaching about how to the develop integrated action plans that draw together the information gathered in assessments, how to analyze that information as to the individual's preferences and	Noncompliance

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		how the priorities can result in clear directions to those working with the individual. Once the "how" of designing integrated action plans has been taught, there will need to be further training on how to link those action plans with service objectives and skill acquisition objectives so that considerations of the individual's interests and priorities and vision for his/her living arrangements and work will be reconciled with medical and safety needs.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Since July 1, 2009, no individuals had been admitted to the Facility. Based on the list of individuals the Facility provided with their most recent and previous PSP dates, 270 out of 286 plans (94%) were completed within one year. They were late on average by 31 days, ranging between one and 145 days late. While it is possible that extensions were granted for some of the 16 plans that was not evident on the provided list. There was evidence in a number of PSPs reviewed that revisions were made when there were changes in the individual's life. For example: ▪ Individual #349 had a Personal Support Plan Addendum when he was discovered to have a serious injury to his toe. The addendum called for additional assistance from the direct support professionals in monitoring, and for a physical therapy consultation to evaluate the need for padding on the foot board of his bed. ▪ Individual #333 had a Personal Support Plan Addendum when he began refusing meals on a regular basis. The team discussed one observation that this individual did not like to have his medications placed in his food as was sometimes done and would refuse to eat it. Another approach was to serve his vegetables on the side, since he did not always like them and would ignore all his food if they appeared on the same plate.	Substantial 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.	DADS Policy #004.V addressed quality assurance processes to ensure PSPs are developed and implemented consistent with the provisions of the SA. Monitoring tools had been adopted, and were being modified for Facility use as described in Section E of this report. This process was at the beginning stages. Base on a review of 13 monthly record/PSP audits, and an audit tracking compilation log, review completed of PSPs were generally thorough and critical. The accuracy to the findings, though, were questionable in some instances, and other concerns were noted with the tool itself. For example; ▪ The inter-rater reliability between the few auditors who were included in the	Noncompliance

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		sample was of concern. For example, one auditor consistently rated a "Yes" for barriers to community transition being identified, and plans addressed to overcome them. The other auditors consistently rated this a "No." It is unlikely that one auditor just happened to review plans were this was adequate. ▪ When evaluating action plans, auditors did not identify issues similar to those of the Monitoring Team. More specifically, they did not comment on the quality of the action plans, and if they contained adequate steps to effectively address all of the individual's support needs. ▪ The tool did not look heavily enough at the integration component, which is essential to compliance with the Settlement Agreement. This likely will need to be evaluated by reviewing the team discussion record, as well as the action plans. The Facility had not yet begun to analyze the data generated from this process. As a result, although the auditors identified many issues, aggregate information was not yet being reviewed and addressed by the QA/QI Council. The Facility's QE processes with regard to PSPs should continue to be refined by modifying review tools as appropriate, training auditor on their use, establishing inter-rater reliability, and analyzing data and addressing problematic trends that are identified.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Personal Support Plan Process policy and associated procedures should be revised to include descriptions of how to design Action Plans, Skill Acquisition Plans, and Service Objectives so that they reflected the interdisciplinary coordination that is required.
2. QMRPs and/or others with responsibility for facilitating team meetings should be provided with additional competency-based training on group facilitation, particularly as is relates to the interdisciplinary team process. The training should include ways to help meeting participants visualize the individual's plan, the individual's contribution to the plan, and the intersection of elements of the plan.
3. Consideration should be given to adding to the PSP process an annual review of incidents, and A/N/E allegations. This would ensure that the team considered how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise.
4. Team members should continue to be provided training on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
5. As indicated in other sections of this report, focused efforts should be made to improve the quality of assessments that are used in the development of individuals' PSPs.
6. The State and the Facility should ensure that person-centered concepts are integrated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences, strengths, etc.
7. As objectives are developed that encourage community integration, efforts should be made to develop and implement skill acquisition

objectives in community settings. Although it is important for individuals to have access to regular recreational opportunities in their community, it also is important for them to have opportunities to learn and practice skills that will result in greater independence in community settings.

8. The Facility is encouraged to continue to address barriers such as transportation, payment of staff's expenses when supporting individuals to participate in recreational and food-related activities, and ensuring adequate staffing is available to enable individuals to participate in community activities in small groups.
9. QMRPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed.
10. Ongoing training should be provided to address gaps in knowledge regarding the new PSP process, as well as to enhance the various team members' skills.
11. The Facility's QE processes with regard to PSPs should continue to be refined by modifying review tools as appropriate, training auditor on their use, establishing inter-rater reliability, and analyzing data and addressing problematic trends that are identified.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Draft DADS Policy #005: Minimum and Integrated Clinical Services, undated; o CCSSLC Policy: Integrated Clinical Services – Table of Contents (related procedures G.1 – G.3.2); o CCSSLC Integrated Clinical Services Procedure G.1: Providing Clinical Care (approved 11/5/10, implementation 12/5/10); o CCSSLC Integrated Clinical Services Procedure G.2: Using Integrated Progress Notes to Provide Integrated Clinical Services and Communication Between Disciplines (approved 11/5/10, implementation 12/5/10); o CCSSLC Physical Nutritional Management Team (PNMT) minutes, for meetings on 8/31/10, and 9/2/10; o CCSSLC Integrated Clinical Services Procedure G.1.2: Epileptic and Psychotropic Management, draft dated 11/23/10; o CCSSLC Integrated Clinical Services Procedure G.1.3: Consultations, draft dated 12/18/10; o CCSSLC Occupational and Physical Therapies Policy P.4: Documenting Meal Monitoring, revised 10/28/10, QA/QI training 12/8/10) o CCSSLC Occupational and Physical Therapies P.4.1 Form: Person-Specific Monitoring in Dining Room; o CCSSLC Occupational and Physical Therapies P.4.2 Form: Competency-Based Monitoring for Staff; o CCSSLC Occupational and Physical Therapies P.4.2: Mealtime Monitoring drill (two pages, dated 11/4/10; o Monthly Person-Specific Meal Monitoring Database: November 2010 for Pacific, Atlantic, Coral Sea, and Tropical, including assigned monitor for each individual; o CCSSLC Nursing Care Policy M.28: Medical Emergency Response, draft dated 12/30/10; o HCG – Medical and Nursing Policy LL.14: Psychotropic/Positive Behavior Support Medical and Nursing, approved 11/4/10, implementation 12/5/10; o DADS SSLC Policy #004: Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports), dated 7/30/10, and training 10/12/10; o Plan of Improvement – Section G; o Minutes of the Integrated Clinical Services Committee, dated 7/5/10; and o Texas Settlement Agreement Monitoring Instrument - Section G. ▪ **Interviews with**: o Dr. Sandra Rodrigues, Medical Director; o Dr. Enrique Venegas, Dental Director; and o Sandi Suri, Pharmacy Director. ▪ **Observations of:** o Integrated Clinical Services Committee meeting, on 7/14/10.

	Facility Self-Assessment: The Facility's POI provided a narrative description of activities in which it had engaged to come into compliance with Section G of the Settlement Agreement. The POI described, for example, that it was in the process of creating policies and procedures to provide guidance to the clinical departments. The Facility indicated that there were 27 procedures developed and used as guides for clinical practice, improvement in the continuity of care, and improved clinical documentation. The POI identified the PNMT as an example of where there had been an improvement in integrated clinical services. Another example of improvement that the Monitoring Team identified was the collaborative efforts of neurology, psychiatry, medical, nursing, and the PST in providing psychotropic medication management. As the Facility's self-assessment process is further developed, a key component will be identifying data and objective documentation sources that can be used to substantiate compliance with these provisions. At the time of this most recent review, it did not appear that such documentation or data existed or had been identified and reviewed. For example, as is discussed with regard to Section G.2, the Monitoring Team requested, but did not receive documentation to substantiate whether or not outside consultation reports were being reviewed and appropriately addressed. This would be an example of data/documentation that the Facility should be reviewing to determine its compliance with this section. Moreover, the "Texas Settlement Agreement Monitoring Instrument" for Section G was submitted. No comments or data had been entered onto the form. Moving forward, the Facility should modify this form, as appropriate, and utilize it to self-assess its own processes. Objective data and information gained from this process should be incorporated into the Facility's POI to substantiate the Facility's findings of substantial compliance or noncompliance. Despite the lack of objective data, the Facility correctly identified that it was noncompliant with these provisions of the Settlement Agreement. Integrating clinical services takes time, training, and guidance to accomplish. Policy development was the first essential step in creating integrated clinical services. The State Office policies were new and/or still under development. However, the Facility had made some remarkable progress in quickly adapting them to clinical care at CCSSLC. The Facility appeared to be on the correct path and progress had been made.
	Summary of Monitor's Assessment: DADS State Office had created a draft Policy #005: Minimum and Integrated Clinical Services, which laid the groundwork and expectations for integrated clinical services. At the time of the Monitoring Team's review, this was a new policy, received at CCSSLC on 12/7/10 for comments. In the meantime, the Medical Department had made enormous strides in adapting the Health Care Guidelines to CCSSLC, and had provided in-service training to the primary care practitioners (PCPs). Several policies were still in the draft stage, and when implemented, will guide physicians in documenting their review of non-Facility consultants' recommendations. However, requests for documentation to support that this was occurring at the time of the most recent review generated no information. Despite the need for continuing improvement, the PNMT was an example of a group that had developed into an interdisciplinary team with strong leadership, and was an example of emerging integrated clinical services.

	The Facility was in the policy writing and implementation stage of growth in moving toward compliance with Sections G.1 and G.2, and the progress was encouraging. However, as expected given the time necessary to establish integrated planning and implementation, they were not yet in compliance with Section G.

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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 DADS State Office draft Policy #005: Minimum and Integrated Clinical Services, received by CCSSLC for comments on 12/7/10, provided the framework on which all clinical services would be operationalized. The focus was on the integration of services and the provision of quality care. Services in each of the clinical disciplines were expected to be "consistent with current, generally accepted professional standards of care within each discipline and with the HealthCare Guidelines I-IX." A number of Facility policies and procedures were created as a follow up to the State policy. These included: ▪ Integrated Clinical Services: Policy G; ▪ Integrated Clinical Services G.1: Providing Clinical Care, approved 11/5/10, implementation 12/5/10; ▪ Integrated Clinical Services G.2: Using Integrated Progress Notes to Provide Integrated Clinical Services and Communication Between Disciplines, approved 11/5/10, implementation 12/5/10; ▪ Integrated Clinical Services G.1.2: Epileptic and Psychotropics Management, draft dated 11/23/10; and ▪ Integrated Clinical Services G.1.3: Consultations, draft dated 12/18/10. Additionally, based on the Table of Contents for the Integrated Clinical Services policies, there were other policies that were not submitted, which should provide additional guidance. The Monitoring Team does not know the stage of development of these policies (draft, approval, implementation): ▪ G.3: Participating In and Completing Integrated Clinical Services Committee Meeting Minutes; ▪ G.3.1: Integrated Clinical Services Meeting Minutes; and ▪ G.3.2: Integrated Clinical Services - Action Steps That Require Collaboration Additionally, 27 procedures were developed, based on the HealthCare Guidelines, which were to be used as guidance in clinical care, in continuity of care, and in documentation of care. These are listed with regard to Section L of the Settlement Agreement. The medical staff and nursing staff had been trained on the implementation of these 27 procedures.	Noncompliance

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		Several other policies were submitted that reflected the integrated clinical approach to providing services to the individual. These included: ▪ Occupational and Physical Therapies Policy P.4: Documenting Meal Monitoring, draft dated 10/28/10, and QA/QI training on 12/8/10. This policy provided guidance regarding the roles and responsibilities of the professionals responsible for monitoring and documenting meals. It included associated documents: "person specific monitoring in dining room," questions to be answered for each individual monitored, "competency based monitoring for staff," a "mealtime monitoring drill," and assignments for members of the integrated team for the month (November 2010 was the example provided) for each individual in each residence that needed meal monitoring; and ▪ Nursing Care Policy M.28: Medical Emergency Response, draft dated 12/30/10. An example of the interdisciplinary integrated approach was the Physical and Nutritional Management Team (PNMT). Minutes were submitted from two meetings of the PNMT, held on 8/31/10, and 9/2/10. Several disciplines were represented and contributed information concerning the care and treatment of the individual(s) and current concerns. As is discussed with regard to Section O of the Settlement Agreement, although the PNMT had areas in which continued improvements were needed, the team was working together in an interdisciplinary manner to ensure that risks were outlined, recommendations made, and measurable goals were established. Since the last review, there had been some collaboration between the Nursing Department and the PNMT regarding safe positioning for individuals when they received medications, orally or enterally; and in the implementation of the new At-Risk Individuals policy. However, there had not been enough collaboration to influence nursing practices. Consistent with the last review, nurses still were not checking the Physical and Nutritional Management Plans (PMNPs) prior to administering medications, although these plans were now being kept in the Medication Administration Records (MARs). The Facility had initiated a Mock Drill Committee to review the medical emergency drills and the emergency response systems. Although only one meeting had been held at the time of the review, the core committee members represented a diverse group from a number of different departments. Although the minutes indicated that there was no representative from the Medical Department at the initial meeting, it was a promising format for collaboration between disciplines regarding the Facility's emergency response systems. As the title of this section indicates, when integration of clinical services occurs, it is	

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		reflected in excellent communication and team building. Each department should see itself as a resource to other departments. At CCSSLC, there continued to be a significant need for growth in communication and collaboration in this area. There had been some noteworthy advances in this area, including the Dental Department's communication with the PSTs and direct support professionals working in the residences. With regard to dental issues, there was further need for improved communication with the QMRPs. There were other examples of where integration of clinical services was lacking and needed improvement. Teamwork between psychology and dentistry was at the beginning stages of developing desensitization programs for individuals who needed them. As is discussed in further detail with regard to Section N, the Psychology and Pharmacy Departments need to meet to collaborate on chemical restraint issues. Infection control should be seen as a collaborative effort involving the Nursing, Medical, Pharmacy, Housekeeping, and Maintenance Departments.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The State Office policy #005 provided expectations and defined responsibilities regarding this provision of the Settlement Agreement. It clearly stated: "the appropriate clinician must review recommendations from non-Facility clinicians and document whether to adopt the recommendations or to refer the recommendations to the personal support team for integration with existing supports and services." Documentation of the recommendations and whether there was agreement from the PCP, with rationale provided if there was disagreement, was written into the following CCSSLC policy: Integrated Clinical Services G.1.2: Epileptic and Psychotropics Management, draft dated 11/23/10. This was one example of the Facility's efforts at clinical collaboration, including documentation of clinical thinking concerning consultants' recommendations. This policy was submitted in a draft stage, and there was no indication that it had been implemented. Further, all these policies were new, and some were still in draft stage. Staff will need training once these policies are approved. At the time of the Monitoring Team's review, there was no data or body of evidence to suggest compliance with this section of the Settlement Agreement. Information regarding compliance was requested, but the Facility did not submit any documentation. However, the Facility had begun to create the systems necessary for this section to be accomplished. Moreover, the "Texas Settlement Agreement Monitoring Instrument" for Section G was submitted. No comments or data had been entered onto the form, verifying that this work remained in an early development phase.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should continue the complex task of finalizing the many policies designed to provide guidance in accomplishing the integration of clinical services.
2. Increased collaboration and communication should occur between the Psychology and Dental Departments, as well as the Psychology and Pharmacy Departments.
3. A quality infection control program should be developed that reflects the philosophy and expertise of integrated clinical services. It should include a team approach and represent many disciplines at CCSSLC, both clinical and non-clinical, including the Nursing, Medical, Dental, Pharmacy, Housekeeping, and Maintenance Departments.
4. The Medical Department should continue to develop and implement policies guiding PCP review of non-Facility clinical consultation, with expectations clearly written into the policy. These might include such steps as documentation in the Integrated Progress Note briefly summarizing the consultants' findings, documenting in the Integrated Progress Note whether or not the PCP is in agreement with the recommendations (if more than one recommendation, then the note should clarify with which recommendations the PCP is in agreement and with which recommendations the PCP is not in agreement). If there is disagreement, the reason for not agreeing with a recommendation and an alternate plan should be documented. As evidence of compliance, the medical QI system should ensure that orders are written verifying agreement of the PCP with the consultant recommendations.
5. Once the policy is approved, then there should be documentation of training for all PCPs. This training should include expectations with regard to written responses to community consultant recommendations.
6. As the Facility's self-assessment process is further developed, the Facility should identify data and objective documentation sources that can be used to substantiate compliance with the provisions in Section G of the Settlement Agreement. The "Texas Settlement Agreement Monitoring Instrument" for Section G should be modified, as appropriate, and the Facility should utilize it to assess its own processes. Objective data and information gained from this process should be incorporated into the Facility's POI to substantiate the Facility's findings of substantial compliance or noncompliance.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Integrated Clinical Services Policy G.1.2: Epileptic and Psychotropics Management, draft dated 11/23/10; o Draft DADS Policy #005: Minimum and Integrated Clinical Services, undated; o HCG – Medical and Nursing Policy LL.14: Psychotropic/Positive Behavior Support Medical and Nursing, approved 11/4/10, implementation 12/5/10; o DADS Policy #004: Personal Support Plan Process - Integrated Protections, Services, Treatments, and Supports, dated 7/30/10, and training 10/12/10; o DADS Policy #006: At Risk Individuals, dated 11/2/10; o Plan of Improvement for Section H; and o Settlement Agreement Section H: Minimum Common Elements of Clinical Care review tool. ▪ **Interviews with**: o Dr. Sandra Rodriguez, Medical Director; o Dr. Enrique Venegas, Dental Director; and o Sandi Suri, Pharmacy Director.
	Facility Self-Assessment: Based on review of the POI and related documents, the State Office had developed three policies that provided the framework, guidance, and expectations needed for compliance with this section. The Facility was adapting the CCSSLC policies to the requirements and expectations of the State Office policies. The DADS Policy #005 encompassed the intent and requirements of this section. At the time of the Monitoring Team's review, the Facility had not had sufficient time to implement many of the new policies, but had begun training in several areas. The Facility's POI indicated that it remained out of compliance with all sub-provisions of the Settlement Agreement. In the comments section, it indicated that, with regard to sub-provision H.2 of the Settlement Agreement, which focuses on psychiatric diagnosis nomenclature being consistent with Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), it met this criterion. However, Section H.2 also required that diagnoses clinically fit the corresponding assessments or evaluations. Consistent with the Monitoring Team's findings, which are discussed in further detail regarding Section J of the Settlement Agreement, the Facility did not find overall compliance with this indicator. The Facility had determined it remained in noncompliance with the remainder of this section, and appeared to realize the many steps that needed to be accomplished to reach this goal. The POI included a statement that on 12/13/10, the QA Department had begun developing an action plan to ensure monitoring of the implementation of the medical procedures. As with other sections of the POI, it will be important for CCSSLC to identify the monitoring tools, and/or data streams that will be utilized to self-assess whether or not the Facility is in compliance with Section H of the Settlement Agreement. Although much of the

	narrative information provided helpful descriptions of the Facility's status and should continue to be included, data also should be used as an objective measure of progress and should be cited in the POI.
	Summary of Monitor's Assessment: DADS State Office had developed a number of policies relevant to Section H of the Settlement Agreement. At CCSSLC, the Departments were focused on developing sound policies and procedures that were consistent with the State Office policies. Much work had been accomplished in this area of policy completion and training. Implementation was the next phase of development. It will take time to both implement and monitor for compliance. All sub-provisions for Section H remained out of compliance, but the Facility was developing the framework for a successful program.

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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.	DADS Policy #005: Minimum and Integrated Clinical Services provided the administrative structure and oversight needed to obtain compliance with Section H of the Settlement Agreement. This policy provided precise guidance concerning such areas as periodicity and timeliness of clinical assessments and evaluations. It provided expectations across a wide range of disciplines, such as quarterly reviews by nurses, annual dental examinations, regular review of drugs, annual physical exams, and periodic assessment of risk status. Changes in status had assessment expectations within 24 hours for non-urgent change, within one hour for urgent change, and immediately for emergent change. With this foundation, the Facility had begun to draft a number of policies. For example, HCG - Medical and Nursing LL13: Psychotropic and Positive Behavior Support Overview, draft dated 11/4/10, and HCG – Medical and Nursing LL.14: Psychotropic/Positive Behavior Support Medical and Nursing, draft dated 11/4/10 were identified in the Facility's Plan of Improvement as examples of the progress towards compliance with Section H.1. At the time of the Monitoring Team's review, the Facility had not had sufficient time to review and comment on DADS Policy #005, and/or to incorporate all of the requirements into their local policies. For example, the DADS policy required identification of health status changes by any staff involved in the care of the individual, as well as timely response from the Nursing and Medical Departments. Many of the policies the Facility already had drafted were based on the Health Care Guidelines. In order to be consistent with State Office policy, the timeliness of response will need to be added to several of these policies, especially those focusing on acute care illness and injury. The two policies mentioned in the Plan of Improvement centered on behaviors and psychotropic medications, an important area needing constant attention with regard to health status and early reporting of change. The DADS policy encompassed more than psychotropic	Noncompliance

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		medication and behavioral plans, and involved all diagnoses and illness across the Facility. Once implemented, recording in the Integrated Progress Notes (IPNs) would need to reflect timely observation of the change in health status, timely reporting, and timely response from the PCP. As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness; individuals who might benefit from communication systems; and individuals being considered for enteral nutrition.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The DADS Policy #005 also set forth expectations for Facility clinical staff, specifically stating "Diagnoses must clinically fit the corresponding assessments or evaluations and 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." As is illustrated with regard to Section J of the Settlement Agreement, the assessment processes used to determine diagnoses were not always consistent with DSM criteria or generally accepted standards of practice. The psychiatric diagnoses utilized at the CCSSLC were consistent with the nomenclature in the DSM-IV-TR. The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which set forth the specific symptoms that the individual presented with in a manner that would support the validity of the psychiatric diagnosis.	Noncompliance
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.	In the DADS Policy #005, there was the expectation/requirement that "treatments and interventions must be timely and clinically appropriate based upon assessments and diagnoses." The DADS Policy #004 Personal Support Plan Process - Integrated Protections, Services, Treatments, and Supports included the entire PST in developing timely treatment interventions. According to the Facility's POI, staff were provided training on the new policy on 10/12/10. Prior to individuals' PSP meetings, a Personal Focus Assessment (PFA) was to be conducted to determine what was important to the individual. Information gained from this process would be used to determine the medical and behavioral assessments that were required. Quarterly meetings were to be held, by the PST, on each individual, which allowed for tracking of success or need to discuss further options. As discussed in detail with regard to Section F of the Settlement Agreement, assessments were missing from many of the PSPs reviewed, the PFA process did not consistently identify all of the assessments that should have been conducted based on the	Noncompliance

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		individuals' needs, and treatments and interventions identified in assessments were not consistently incorporated into individuals PSPs. DADS new Policy #006 - At Risk Individuals addressed change of status, risk guidelines, as well as ongoing and quarterly risk review. This provided another mechanism to ensure areas of health concern were not overlooked, but were addressed methodically. CCSSLC was at the very initial stages of implementing this policy.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	In DADS Policy #005, the expectation/requirement was set forth that: "clinical indicators of the efficacy of treatments and interventions are determined in a clinically justified manner." The State Office then provided guidance for several areas of healthcare by referring the clinical departments to specific guidelines, which national organizations with expertise in specific areas of healthcare had developed and continued to update. The scope of practice covered by these guidelines was wide ranging, including preventive care, immunizations, cardiac care, diabetic care, breast cancer, cervical cancer, pneumonia, depression, and other guidelines available through the US Agency for Healthcare Quality and Research. The State Office clearly had identified a framework and level of expectation with regard to the quality of care. Based on these guidelines, the policy further stated "the facility must develop a system to identify which guidelines to follow …" At the Facility, the staff had been trained on DADS Policy #004 and #006. These were important steps in making progress toward the creation and implementation of clinical indicators, and tracking of the effectiveness of treatment. However, a great deal of additional work needed to be done. As is illustrated in various sections of this report, clinical indicators often were not identified. For example, when psychiatric medications were prescribed, the target symptoms were generally not tracked. Tracking these symptoms would assist in determining the efficacy of the treatment. Likewise, nursing plans did not identify what clinical indicators would be tracked, by whom, or when. Many PNMPs also did not identify the functional outcomes to be measured.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	DADS Policy #005 also set the standards and expectations the Medical Director needed to use in creating a health status monitoring system. The expectation appropriately, but ambitiously set the standard as monthly monitoring on a wide variety of domains of health care, including staffing, timeliness, equipment and resources, quality of care, morbidity, clinical indicators, etc. At the time of the Monitoring Team's onsite review, CCSSLC had not yet developed or begun to implement such a system. The Monitoring Team looks forward to reviewing such a system during upcoming reviews. As is discussed above with regard to Section E.1 of the SA, such indicators need to be	Noncompliance

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		incorporated into the QE/Risk Management systems to identify individuals, residences, and/or departments that need attention, as well as to detect and address systemic issues that impact the Facility's adequate response to clinical indicators. Additionally, DADS Policy #006, on which staff across the Facility already had been provided in-service training, provided guidance on health status changes and periodic reviews. The next phase of this process was full implementation.	
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.	DADS Policy #005 also set the standard and expectations for the Medical Department with regard to this provision when it stated: "Clinicians are expected to act on reports from other staff, monitor the individual themselves, note the effects of interventions, and make changes to treatments and interventions in response to clinical indicators and as warranted." As already mentioned, the Facility had not developed and implemented clinical indicators from clinical guidelines that could be used as a measuring tool to identify medical issues and provide interventions. Additionally, DADS Policy #006 – At Risk Individuals; included the requirement of a timeline once a significant change in health status was identified. The PST was responsible for timely assessment beginning, at least within five days, and the creation of an interdisciplinary plan within 14 days, with implementation and continued follow up. As already noted, the Facility was in the initial stages of implementing this policy.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Various policies had been developed describing the requirements, expectations, and process for implementing integrated clinical services and the minimum common elements for clinical care. These included the following: ▪ Integrated Clinical Services G.1.2: Epileptic and Psychotropic Management, draft dated 11/23/10; ▪ HCG – Medical and Nursing LL.14: Psychotropic/Positive Behavior Support Medical and Nursing, dated 11/4/10, implementation 12/5/10. This was one of the 27 policies the Medical and Nursing Departments developed to ensure integration of quality clinical services. A listing of other relevant policies is included below with regard to Section L of the Settlement Agreement; ▪ DADS SSLC Policy #004, dated 7/30/10: Personal Support Plan Process - Integrated Protections, Services, Treatments, and Supports, training completed 10/12/10. As this process was just beginning across the campus, the Facility had not used the "Settlement Agreement Section H: Minimum Common Elements of Clinical Care" to review records to ensure compliance with this section.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should continue to complete policies that were still in the draft phase of development. The Facility policies should reflect the timeliness of response required in the State Office policy with focus on consistency of timeliness related to acute illness and injury.
2. Given the number of new policies and breadth of topics covered, along with the clear expectations written into the policies, in-service training should be thorough, and repeated at regular intervals. The staff of the Medical, Dental, and Pharmacy Departments should have the opportunity to ask questions and obtain clarification during training sessions. Focus should be on how to implement the State and Facility policies consistently through all departments. An additional in-service topic should be the monitoring and feedback of the process. In other words, staff should be trained on what will be measured, what the measurement indicators will be, and threshold levels for interpretation and action.
3. Feedback on performance should be department specific (i.e., results should be shared only among peers in a learning environment, with discussion among peers on improving challenging issues). The Medical Director should play an instrumental role in facilitating these various meetings.
4. The DADS Policies #004 and #006, and draft Policy #005 are broad in scope and several in-service training sessions might be required to review the different sections of the lengthier policies. Alternatively, the Medical Director and Medical QA Nurse might need to provide in-service training to each of the clinical departments separately, tailoring the training to the areas that impact the department directly, and providing clarity on the department's implementation requirements and responsibilities.
5. DADS draft Policy #005 listed many expectations that would require the Medical Director to complete monthly monitoring on a wide variety of domains of healthcare. These should be prioritized, timelines created, and followed. Collaboration and assistance from other personnel and departments should be provided as necessary to assist the Medical Director.
6. CCSSLC should identify the monitoring tools, and/or data streams that will be utilized to self-assess whether or not the Facility is in compliance with Section H of the Settlement Agreement. The narrative descriptions of the Facility's status should continue to be included, but data also should be included as another objective measure of progress.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Medical Care Policy LL.18.2: The Prevention and Management of Aspiration Pneumonia, draft/revision 12/6/10, 12/22/10; o Email dated 12/17/10 concerning mandatory training on at-risk determinations for aspiration pneumonia; o Email dated 12/29/10 concerning aspiration pneumonia initiative database; o DADS Policy #006: At Risk Individuals, dated 11/2/10; o Copy of Webinar training materials, dated12/21/10; o PSP dated 12/1/10 for Individual #70; o Integrated risk rating form; o Risk action plan (sample draft); o Risk process flowchart; o Aspiration triggers data sheet; o Risk guidelines – draft; o Team leader daily resident flow sheet; o Direct Care Professional (DCP) daily flow sheet; o Weekly flow chart; o Weekly flow sheet; o Interdisciplinary aspiration pneumonia prevention algorithm; o Aspiration pneumonia/enteral nutrition evaluation (draft); o Apartment 524A CCSSLC – Initial Risk Assessments and Ratings Tracking FY-11 January 2011 through March 2011; o SSLC At Risk Training – PSP Meeting follow up at Facility; o Introduction to Risk Post Test; o CCSSLC Policy: Residential Services W.2: Documenting in the Observation Notes, revised 12/30/10, approval 12/30/10, implementation 1/30/11; o Form: Aspiration Triggers Occurrences – Documentation Process; o CCSSLC Policy: At Risk Individuals I.1 VI.2: Health Status Team, approved 11/5/10, implemented 12/5/10 (policy no longer in effect); o CCSSLC Policy: At Risk Individuals I.2. VI.2: Actions Following Health Status Team Meeting, approved 11/5/10, implementation 12/5/10 (policy no longer in effect); o CCSSLC Policy: At Risk Individuals I.3. VI.2: High Risk Oversight Committee, approved 11/5/10, implementation 12/5/10; o Health risk assessment rating tool; o Health risk assessment tool – aspiration/choking; o Health risk assessment tool – weight; o Health risk assessment tool – nursing; o Health risk assessment tool – polypharmacy; o Risk assessment tool – challenging behavior;

	○ Health risk assessment tool – injury; ○ Individuals dining by mouth diagnosed with pneumonia, from 6/1/10 to 1/7/11; ○ Individuals identified as "at risk" for seizures; ○ Individuals identified with diagnosis of pica disorder; ○ Individuals identified as "at risk" for pica; ○ Individuals with tracheostomy; ○ Individuals identified as "at risk" for aspiration; ○ Individuals identified as "at risk" for pneumonia; ○ Individuals diagnosed with pneumonia between 11/1/09 and 11/16/10; ○ Individuals identified as "at risk" for GERD; ○ Individuals identified as "at risk" for choking; ○ Individuals identified as "at risk" for dysphagia; ○ Individuals experiencing swallowing incidents during time period from 11/1/09 to 11/16/10; ○ Individuals identified as "at risk" for chronic respiratory infections/pneumonia; ○ Individuals identified as "at risk" for constipation; ○ Individuals identified as "at risk" for skin breakdown/decubitus ulcers; ○ Individuals identified as "at risk" for falls; ○ Individuals who have sustained a bone fracture between 11/1/09 and 11/16/10; ○ Individuals identified as "at risk" for dehydration; ○ Individuals identified as "at risk" for osteopenia/osteoporosis; and ○ Medical records for the following: Individual #130, Individual #27, Individual #58, Individual #173, and Individual #311. ▪ **Interviews with**: ○ Iva Benson, Facility Director; ○ Mark Cazales, Assistant Director of Programs; ○ Daniel Dickson, Director for Quality Improvement; ○ Colleen Gonzales, Chief Nursing Executive; and ○ Dr. Sandra Rodrigues, Medical Director. ▪ **Observations of:** ○ PST Meeting for Individual #338, on 1/6/11.
	Facility Self-Assessment: The Facility's POI indicated that the Facility just recently had completed training on the new policy on At Risk Individuals. According to the POI, a total of 11 PSPs had been completed using the new policy. The POI correctly identified that the Facility was at the initial stages of these processes. It indicated that the Facility remained out of compliance with all of the provisions of Section I. The Facility's POI included a narrative description of some of the recent activities undertaken to attain compliance. The narrative incorporated limited quantitative data. As the Facility's self-assessment processes continue to be developed, the POI should include additional information. Monitoring initiatives and data streams should be identified and designed to evaluate both quantitative as well as qualitative indicators. For example, the current POI provided data with regard to the numbers of PSPs developed

	using the new policy and procedures, but did not provide information regarding assessment of the quality of those PSPs, particularly with regard to the adequacy of team's assessment and planning activities related to the individuals' identified areas of risk. While it is important to continue to provide narrative discussion of actions being taken to move toward compliance, these next steps are necessary to ensure that the Facility is able to self-assess its compliance with the requirements of Section I.
	Summary of Monitor's Assessment: DADS Policy #006: At Risk Individuals, revised 11/2/10, was submitted in draft format. Based on this, an At-Risk Individuals Policy Training webinar was created and provided to CCSSLC staff. There were two trainings, held on 12/21/10 and 12/28/10, and the request was for full attendance by identified staff/departments on one of those days. The State and Facility chose aspiration pneumonia as the first priority condition for risk evaluation and implementation of risk reduction steps, due to the high rate of deaths from aspiration pneumonia. The policy on At-Risk Individuals and the plan related to aspiration pneumonia were well thought out. At the time of the review, they remained to be implemented. The major implementation concern was the intensity of activity required from many departments. The amount of training on treatment of and clinical observation of aspiration, and the voluminous documentation process will be challenging to implement. This is an example of an implementation effort that will require an integrated approach, including, but not limited to medical, nursing, habilitation, residential, and day/vocational staff. As is noted in the other sections of this report that address medical, nursing, and habilitation therapies, the competencies of some of these staff were not sufficient to develop and implement treatment plans to address the needs of individuals at high-risk for aspiration and other conditions. The State and Facility will need to address such competency issues in order for the full effects of the new policy to be realized. The Facility was at the very initial stages of implementing the revised policy. Given the number of stops and starts related to the at-risk initiative, one of the Monitoring Team's concerns is that the staff and Administration will be demoralized by setbacks, when the process that has been created appeared to be appropriate. There seemed to be an underestimation of the time and energy required to implement a plan of this magnitude. A measured approach to implementation, such as the use of a pilot group of individuals, followed by a well planned but expeditious rollout should be considered to ensure momentum is maintained and ultimately the goals are achieved.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals	DADS Policy #006: At Risk Individuals, revised 11/2/10, was submitted in draft format. Based on this, an At-Risk Individuals Policy Training webinar was created and provided to CCSSLC staff. Copies of the slides were submitted for the Monitoring Team's review. There were two trainings, held on 12/21/10 and 12/28/10, and the request was for full attendance by identified staff/departments on one of those days. The training provided information concerning the Settlement Agreement, the Monitoring Team's recommendations, as well as details of the policy.	Noncompliance

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	whose health or well-being is at risk.	The new policy indicated that nursing staff in conjunction with the primary care practitioner (PCP) was responsible for assessing risk factors in the following categories: Aspiration, Respiratory Compromise, Cardiac Disease, Constipation/Bowel Obstruction, Diabetes, Gastrointestinal (GI) Problems, Osteoporosis, Seizures, Skin Integrity, Infections, Fractures, Fluid Imbalance, Hypothermia, Urinary Tract Infections (UTIs), and Circulatory issues. The following comments are offered with regard to the draft policy: ▪ In relation to the risk level delineations, the highest risk level included those for whom there was a sense of urgency to separate this category from the other two. This will be a vital distinction as the teams begin to prioritize individuals and their various risks. ▪ The PNMT should play a crucial role in the assessment and plan development for individuals with certain types of risk. Although the description of the PNMT in the draft policy included the core members the Settlement Agreement requires, the important role of a physician member could play should be not be ignored. This role could be as a consultant to review the initial findings and plans, and/or those needing urgent revision to ensure all aspects are appropriate from a medical perspective. However, the PNMT should not be administered without provision of physician oversight or integration of the medical component. ▪ The policy stated that the PST or primary care practitioner (PCP) "may refer... to the PNMT for health risk." The assumption should be that a referral would be made for those areas of expertise for which the PNMT is qualified, recognizing there are many health conditions beyond the scope for which the PNMT is intended. ▪ That either the PST or PCP would be able to make a referral to the PNMT was an important step. The PCP could consult with the PNMT, at times, much more efficiently, especially when the need is urgent, without waiting for the time delays in gathering the members of a PST for discussion and decision. ▪ The risk guidelines included a long list of risk domains, with the responsible department identified. On a positive note, most of the domains required cooperation between two departments, theoretically necessitating integration of clinical efforts as training and insight are provided in each of the domains. ▪ Based on the draft policy, requirements related to ongoing monitoring for positive outcomes appeared to be intensive. ▪ An example of a PSP with the PST decisions related to areas of risk and level of risk was included. Importantly, the thought process/justification of the PST in determining the level of risk assigned was recorded. The PSP was a well-chosen example, as it gave examples of levels of risk in different domains (for instance, high risk for osteoporosis, seizures, and dental, and medium risk for aspiration,	

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		constipation, GI, and polypharmacy). Caution should be applied in compartmentalizing these areas. Although it may be easier to consider them individually, there is considerable clinical overlap. It will be necessary to assist team members in understanding the complexity of this undertaking. For instance, gastrointestinal (GI) issues, and especially GERD, might lead to aspiration and respiratory problems. In the example, the depth of recording of the rationale was excellent. This level of expectation will require teams to thoroughly consider each risk, and solidify their justifications in writing. This will create a better plan. ▪ Also, the elimination of the numbering system for rating the level of risk was a welcome change. Staff might confuse the meaning of "#1," but are not likely to confuse the meaning of "high risk." ▪ Additional forms in the submitted packet were designed to assist the team in implementing the policy, including: an integrated risk rating form, risk guidelines draft, a risk process flowchart, a Direct Care Professional (DCP) daily flow sheet, a weekly flow chart, a weekly three-page resident flow sheet listing various generic concerns (level of consciousness, pain, injury, pica, refusal of care, lab results), and a team leader daily resident flow sheet, and a risk action plan. After the Webinar training, there was a post-test for "introduction to risk." This included 10 questions for the attendees to answer. The State and Facility chose aspiration pneumonia as the first priority condition for risk evaluation and implementation of risk reduction steps, due to the high rate of deaths from aspiration pneumonia. The aspiration pneumonia initiative included an "Interdisciplinary Aspiration Pneumonia Prevention Algorithm," Aspiration Triggers Data Sheet (two forms), and a draft aspiration pneumonia/enteral nutrition evaluation. A policy entitled "Medical Care LL.18.2: The prevention and management of aspiration pneumonia," with revision dates of 12/6/10 and 12/22/10 provided excellent guidance to the staff. It designated the duties of the PCP, nursing staff, and DCP staff. There was also additional guidance to the direct support professionals provided in a separate policy entitled "Residential Services W.2: Documenting in the Observation Notes," dated 12/30/10, with implementation on 1/30/11. This document provided guidance in completing a form "aspiration triggers occurrences – documentation process." Based on discussions with staff, a workgroup had developed/revised the observation form and process. The workgroup included direct support professionals. This illustrated the Facility's commitment to involving all staff in the change process, and ensuring that appropriate input was obtained with the expectation that this would result	

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		in practical and sustained change. Monitoring Team members saw this new form in use. A sample of direct support professionals was able to describe how they were to complete it, including their role in identifying some of the aspiration triggers. The policy on At-Risk Individuals and the plan related to aspiration pneumonia were well thought out. At the time of the review, they remained to be implemented. The major implementation concern was the intensity of activity required from many departments. The amount of training on treatment of and clinical observation of aspiration, and the voluminous documentation process will be challenging to implement. It will take constant oversight and an ability to quickly amend the forms and the system, if necessary, to create a workable system that will reduce the rate of aspiration pneumonia. It is recommended that the Facility learn from prior experience with health risk assessment and health status teams. Rather than implementing this across the campus, it would be helpful to pilot it to ensure problem areas are resolved on a smaller scale. Full implementation of this policy will require full-time staff with responsibilities for training and monitoring to ensure it is implemented, and implemented correctly. It was not clear that the level of staff needed had been assigned or recruited to the project, or that the necessary intensive training or technical assistance had been provided. This is an example of an implementation effort that will require an integrated approach, including, but not limited to medical, nursing, habilitation, residential, and day/vocational staff. As is noted in the other sections of this report that address medical, nursing, and habilitation therapies, the competencies of some of these staff were not sufficient to develop and implement treatment plans to address the needs of individuals at high-risk for aspiration and other conditions. The State and Facility will need to address such competency issues in order for the full effects of the new policy to be realized. Given the number of stops and starts related to the at-risk initiative, one of the Monitoring Team's concerns is that the staff and Administration will be demoralized by setbacks, when the process that has been created appeared to be appropriate. There seemed to be an underestimation of the time and energy required to implement a plan of this magnitude. A measured approach to implementation, such as the use of a pilot group of individuals, followed by a well planned but expeditious rollout should be considered to ensure momentum is maintained and ultimately the goals are achieved. The Facility had begun to generate lists of individuals at risk. For example, there was a list entitled: "Apartment 524A. CCSSLC – Initial Risk Assessments and Ratings Tracking FY-11 January 2011 – March 2011." It listed those with enteral nutrition, and also those who had had an episode of aspiration pneumonia since 5/09, including the number of such events. In addition, using the new guidelines, the Facility had identified a list of approximately 90 individual at risk for aspiration.	

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		Additional risk could be identified through a number of database printouts that were submitted. If they were valid and sufficiently completed, then they represented many opportunities to begin to look at those that are at highest risk. For example, a list entitled: "Individuals dining by mouth diagnosed with pneumonia 6/1/10-1/7/11" would allow a review of those who might not have feeding tubes to prevent or minimize complications of dysphagia, but were likely to be candidates in the near future. Of those listed, individuals that required thickened liquids were the most at risk, compounded by the fact that this was a list of those that already had pneumonia. These individuals should have had a recent Modified Barium Swallow Study (MBSS) to ensure they remained safe at this texture. Triggers while eating should have been taught to the direct support professionals, monitored at each meal, and recorded and monitored for any trend changes over time. Other lists that were submitted could be used to point the interdisciplinary teams and the Medical Department toward subpopulations at greatest risk for a variety of disease entities. Those lists of "at risk" categories were presumably based on the PST decision of priority health areas. Although the old risk policy and system had been changed and updated, the information already gathered in creating previous "at risk" lists should be used to ensure that each individual with former high priority concerns is evaluated quickly and their needs continue to be addressed. The process has changed, but the clinical body of information driving the decision process remains fairly constant. These lists included: ▪ Individuals identified as "at risk" for chronic respiratory infections/pneumonias; ▪ Individuals diagnosed with pneumonia between 11/1/09 and 11/16/10; ▪ Individuals identified as "at risk" for pneumonia; ▪ Individuals diagnosed as "at risk" for choking; ▪ Individuals experiencing swallowing incidents during time period; ▪ Individuals identified as "at risk" for dysphagia; ▪ Individuals identified as "at risk" for aspiration; ▪ Individuals identified as "at risk" for gastroesophageal reflux disease (GERD); ▪ Individuals admitted to the emergency room between 11/1/09 and 11/16/10; ▪ Individuals admitted to the hospital; ▪ Infirmary admissions; ▪ Individuals identified with diagnosis of pica disorder; ▪ Individuals identified as "at risk" for pica disorder; ▪ Individuals identified as "at risk" for skin breakdown/decubitus ulcer; ▪ Individuals identified as "at risk" for constipation; ▪ Individuals identified as "at risk" for aspiration; ▪ Individuals identified as "at risk" for dehydration; ▪ Individuals identified as "at risk" for seizures;	

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		▪ Individuals who have sustained a bone fracture between 11/1/09 and 11/16/10; ▪ Individuals identified as "at risk" for falls; and ▪ Individuals identified as 'at risk" for osteopenia/osteoporosis.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Several other policies were approved and implemented to provide guidance on how to implement the "at risk" reviews by the PSTs. However, as noted below, many of these already were out-of-date due to changes in policy at the State level. These included: ▪ *At risk individuals: I.1 VI.2: Health Status Team*, approved 11/5/10, implementation 12/5/10 [this had been replaced by the current at-risk policy initiative, as the HST function has been incorporated into the PST]; ▪ *At risk individuals I.2 VI.2: Actions Following Health Status Team Meeting,* approved 11/5/10, implementation 12/5/10 [this has been replaced by the current at-risk policy initiative]; ▪ *At risk individuals I.3 VI.2: High Risk Oversight Committee,* approved 11/5/10, implementation 12/5/10; ▪ *Health risk assessment rating tool – high, medium, low;* ▪ *Health risk assessment tool – aspiration/choking;* ▪ *Health risk assessment tool - weight;* ▪ *Health risk assessment tool - nursing;* ▪ *Health risk assessment tool – polypharmacy;* ▪ *Risk assessment tool – challenging behavior; and* ▪ *Health risk assessment tool – injury.* These tools likely will need to be reviewed and updated to agree with clinical guidelines and policies that had been or were in the process of being created or finalized. At the time of the review, the At-Risk Individuals policy was fairly new, and teams had just begun to implement it. As of 12/10/10, there were 11 annual PSPs completed using the new at risk policy. A review of five individuals (Individual #130, Individual #27, Individual #58, Individual #173, and Individual #311), who were at high risk for aspiration pneumonia, and had been hospitalized within the past six months for aspiration pneumonia identified the following problematic issues regarding nursing care: ▪ A lack of recognition that the respiratory symptoms the individuals experienced were signs of changes in status and warranted nursing assessments; ▪ Nursing not responding or responding timely to the concerns of direct support professionals regarding assessing an individual's status; ▪ Nurses not consistently documenting the type of temperatures taken; ▪ Inconsistent follow-up from symptoms noted in previous nurses' progress notes;	Noncompliance

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		▪ Lack of mental status assessments documented during periods of status changes; ▪ Inappropriate and non-specific documentation of lung sounds; ▪ The lack of lung sounds routinely assessed and documented for respiratory issues; ▪ Physician/Practitioner not timely notified when changes in status began to occur; ▪ A lack of documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration; ▪ No indication if oxygen saturations documented were reflective of room air; ▪ A lack of an adequate assessments regarding the individual's status and mental status at the time of transfer to and from the Infirmary, hospital, or emergency room; ▪ Inconsistent documentation that the nurse or physician notified the receiving community facility of the individual's transfer; ▪ Inconsistent documentation of the exact time, date, and/or method of transfer to the receiving facility in the progress notes; ▪ Lack of a complete nursing assessment upon return to the Facility, especially addressing the very symptoms that precipitated the transfer; and ▪ The lack of ongoing follow-up assessments after transfer back to the Facility addressing the symptoms that precipitated the transfer. These findings were similar to the findings from the past two reviews. Thus far, there had been no noticeable improvement in the nursing care and documentation for individuals with health risk issues. In order for the risk system to be effective, the lack of clinical competency in nursing regarding the identification and implementation of clinically appropriate interventions must be addressed. The lack of identification of individuals who are at risk, and require assessment and intense clinical attention is clearly a barrier to building a successful system to ameliorate risk to the extent possible, and address risk factors when they do occur.	
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,	As already mentioned, the At- Risk Individuals policy was new to CCSSLC. The aspiration pneumonia initiative also was new. It was anticipated that during the upcoming quarter, those at risk would be identified, and the creation and implementation of the risk plans would occur. However, there had been little opportunity for the teams to meet to implement the new policy.	Noncompliance

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	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.		

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. A physician should be appointed as a member of the PNMT, or a physician appointed as a consultant to the PNMT to provide medical input on decisions and recommendations, and as a liaison to the medical staff.
2. As illustrated in the sample PSP included in the training packet, PSTs should document clearly the rationale used to identify the risk domains and the level of risk.
3. Full time staff should be assigned to the roll out of the at risk policy and aspiration pneumonia prevention initiative until the system is in place.
4. The aspiration risk initiative should be piloted in one unit before implementing it campus-wide. This should be followed by a well planned but expeditious rollout to ensure momentum is maintained and ultimately the goals are achieved.
5. The State and Facility should identify needs with regard to the training and clinical competence of staff that have the ability to weaken or derail efforts to implement an effective system to address the needs of individuals at-risk in a variety of categories, including risks related to aspiration. The State and Facility should develop and implement a plan to address these needs. Many other sections of this report identify issues related to the training and clinical competence of the clinical staff and other professionals responsible for the assessment, planning, and implementation tasks that will be key to the success of the at-risk initiatives.
6. The former risk lists still have validity for many health domains and should be used as a resource in guiding priority areas for risk management across the campus during this transition.
7. The lack of clinical competency in nursing regarding the identification and implementation of clinically appropriate interventions must be addressed, including but not limited to the lack of identification of individuals who are at risk, and require assessment and intense clinical attention.

The following are offered as additional suggestions to the State and Facility:

1. As the scope of the PNMT has expanded with the introduction of the revised At-Risk Individuals policy, the Facility should strongly consider assigning members full-time to the PNMT. The at-risk system likely will be hampered if the PNMT members have other primary duties.
2. The Facility should develop a panel of internal and external resources to be utilized in assisting teams as they identify risk domains with unresolved issues or as teams needs guidance on specific risks.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Policies Related to the Use of Pre-Treatment Sedation Medication, revised 11/15/10; o Spreadsheet of individuals who have received pre-treatment sedation medication in the last six months for medical or dental procedures, name and dosage of medication, including date of administration and indication as to whether a Desensitization Plan was in effect; o Monthly Sedation Usage Report(s) from 6/1/10 to 11/16/10; o Job Descriptions of Psychiatrists; o List of individuals whose psychiatric diagnoses have been revised, along with the Psychiatrists' rationale for the new diagnosis; o List of Individuals Prescribed Intra-Class Polypharmacy; o Schedule and Dates of All Psychiatric Treatment Reviews for the last six months; o List of all meetings and rounds that are typically attended by the Psychiatrist, including other professional disciplines that usually attend those meetings; o Blank copies of the Professional Service Log for Psychiatrists; the Psychiatric Evaluation Form; the CCSSLC Quarterly Psychiatric Review Form; and the CCSSLC Monthly Psychiatric Review Form; o List of CCSSLC Board Certified Psychiatrists; o List of Support Services for Psychiatry Department; o Minutes of Polypharmacy Reviews for the last six months; o Response to requests for documentation pertaining to complaints about the psychiatric and medical care at CCSSLC, indicating No complaints; o Current list of families/guardians that refused to authorize psychiatric treatments and/or medication recommendation; o Lists of Individuals with Tardive Dyskinesia, and Individuals Being Monitored for Tardive Dyskinesia; o The new DADS State-Supported Living Centers Risk Assessment Protocols, and related materials/tools; o List of Individuals Being Prescribed: a) Lithium; b) Tricyclic Antidepressants; c) Trazodone; d) Beta Blockers as a psychotropic medication; e) Clozapine; and f) Mellaril; o Policy for Prescribing Psychoactive Medication, revised 11/15/10; o List of all individuals prescribed psychotropic medication, including diagnosis, name of medication, and dosage; o List of all Individuals receiving anticonvulsant medication; o The completed Reiss Screen for the following: Individual #266, Individual #327, Individual #37, Individual #206, Individual #187, Individual #208, Individual #65, Individual #207, Individual #182, Individual #102, Individual #31, Individual #86, Individual #215, Individual #276, Individual #48, Individual #339, Individual #126,

		Individual #205, Individual #24, Individual #222, Individual #113, Individual #393, Individual #32, Individual #15, Individual #366, Individual #179, and Individual #270; o Spreadsheet of Reiss Screen Examinations, with due date and Delinquency Report for all CCSSLC individuals as of 7/14/10; o List of Individuals Reviewed during 1/4/11 and 1/5/11 Psychiatry Clinics; o Challenging Behaviors Report on all individuals at CCSSLC; o CCSSLC Plan of Improvement (POI) for the Psychiatry Department, Section J; o List of Individuals Receiving Anticholinergic Medication; o List of Individuals Prescribed Benzodiazepines; o The following sections of the Medical Record: Face Sheet, Social History, Rights Assessment, Consents for Psychotropic Medication, Consents for Pre-Treatment Sedation Medication, HRC Referral Form and Addendums related to Psychotropic Medication, Behavioral Support section, Hospital section, Psychiatry section, Side Effect section, Pharmacy section, and the Neurology Consultation section for the following: Individual #255, Individual #172, Individual #58, Individual #295, Individual #296, Individual #230, Individual #322, Individual #19, Individual #344, Individual #103, Individual #196, Individual #133, Individual #52, Individual #153, Individual #305, Individual #46, Individual #18, Individual #211, Individual #146, Individual #327, Individual #333, Individual #202, Individual #237, Individual #353, Individual #308, Individual #136, Individual #281, Individual #10, and Individual #141. NOTE: These individuals comprised a random sample of 20% of individuals receiving psychotropic medication. However, the complete records of Individual #103 and Individual #211 could not be fully reproduced, as these medical records were located in their residences, which were under quarantine; o Presentation Book for Psychiatry section, dated 12/10; o The Reiss Screen master spreadsheet, dated 12/10; o The master spreadsheet for completion of the Monitoring of Side Effects Scale (MOSES)/ Dyskinesia Identification System: Condensed User Scale (DISCUS), dated 12/10; o List of Individuals Receiving Reglan as of 1/3/11; o Master spreadsheet of Neurology Consultations that have been reviewed by the Psychiatrist and the psychiatric team, dated 12/10; o Schedule and dates of all Psychiatric Treatment Reviews for the last six months, requested 1/3/10; o List of Psychotropic Medication Consents with dates, requested 1/3/10; o Psychiatric Consultation Notes on the following: Individual #285, dated 2/15/10; Individual #47, dated 10/12/10; Individual #19, dated 12/15/10; and Individual #176, dated 10/5/10; o Curricula Vitae (CV) and Contracts for the locum tenens Psychiatrists, Drs. Patel and Elequin; o The 10 most recent comprehensive Psychiatric Assessments prepared by Dr. Hernandez; o The schedule and related documentation for the Psychiatry Clinics on 1/4/11 – Seahorse and Sand dollar Residences;

	- The Neurology Clinic Consultations for Individual #49, dated 12/18/10; and Individual #292, dated 11/27/10; - The MOSES and DISCUS Side Effect Rating Scores for the last year for the following individuals receiving Reglan: Individual #15, Individual #239, Individual #43, Individual #113, and Individual #195; - List of individuals whose July 2010 Reiss Score were elevated above the clinical cut-off level, and copies of the resulting Psychiatric Evaluations that were performed by Dr. Hernandez; - List of Individuals with Behavioral Desensitization Plans for Medical and Dental Appointments, and examples of five recently completed plans from Psychology; - Team Meeting Roster/Sign-In Sheets and Minutes from Desensitization and Pre-Treatment Sedation Meeting of 10/28/10; - Sign-In Sheets for Pre-Treatment Sedation Policy In-Service on 11/19/10; - Schedule and Summary Sheets for the Psychiatric Clinics on Pompano and Angelfish Residences on 1/5/11; - The Psychiatric Consultations that would have been precipitated by elevated scores from the Reiss Screenings for the following individuals: Individual #206, dated 7/5/10; Individual #208, dated 7/20/10, and Individual #339, dated 7/9/10; - Copy of the advertisements that had been placed to hire a Psychiatrist, and list of the publications in which they appeared; - Minutes from the last six months of Pharmacy and Therapeutics (P & T) Committee Meetings, including any attachments and addendums; and - CCSSLC Evidence Book for Section J, Psychiatric Services, which contained the following sections: a) Compliance Review; b) Plan of Improvement, including the newly revised Plan of Improvement; c) Monitoring Tools; d) Evidence J.1 through J.15; and e) Recommendations one through three and Recommendations seven through 10. ▪ **Interviews with**: - Glynn Bogard, Psychiatric Assistant, on 1/13/11, 1/4/11, and 1/6/11; - Michelle P. Lora-Arteaga, R.N., Psychiatric Nurse, on 1/3/11, 1/4/11, and 1/6/11; - Brinda Fuller, R.N., Psychiatric Nurse, on 1/3/11, and 1/6/11; - Joseph Ward, Psychiatric Assistant, on 1/3/11, and 1/6/11; - Michael Hernandez, M.D., Consulting Psychiatrist, on 1/4/11; - Robert Cramer, Psy.D., Clinical Psychologist, on 1/4/11; - Everett Bush, Associate Psychologist, on 1/4/11; - Mina Nguyen, Clinical Pharmacist, on 1/5/11; and - Sandra Rodrigues, M.D., Medical Director, on 1/5/11. ▪ **Observations of**: - Psychiatric Clinic on Seahorse Residence, on 1/4/11; - Psychiatric Clinic on Sand dollar Residence, on 1/4/11; - Behavioral Support Committee Meeting, on 1/4/11; - Psychiatric Clinic on Pompano Residence, on 1/5/11; - Psychiatric Clinic on Angelfish Residence, on 1/5/11;

	- Human Rights Committee Meeting, on 1/5/11; and - Observations of the following individuals: Individual #176, Individual #21, Individual #88, Individual #186, Individual #158, Individual #172, Individual #255, Individual #114, Individual #206, Individual #95, Individual #174, Individual #92, Individual #246, Individual #267, Individual #20, Individual #41, Individual #312, Individual #295, Individual #112, Individual #238, Individual #47, Individual #325, Individual #243, Individual #176, Individual #316, Individual #195, Individual #278, Individual #154, Individual #233, Individual #51, Individual #138, Individual #117, Individual #369, Individual #357, Individual #224, Individual #133, Individual #279, Individual #275, Individual #298, Individual #300, Individual #177, Individual #47, Individual #166, Individual #186, Individual #132, Individual #308, and Individual #294.
	Facility Self-Assessment: The Evidence Book that the Psychiatry Department prepared indicated they paid close attention to the prior monitoring report and related recommendations. The specific actions that had been implemented in response to those recommendations are detailed in the report that follows. As indicated in the Facility Plan of Improvement, many of the new systemic changes were only in the beginning stages of implementation. As a result, the effects of these changes were not fully evident during this monitoring review. The template that the Facility had developed for their Internal Compliance Review of individual records was detailed. It covered the subject matter discussed in the sub-sections of the Psychiatry section of the Settlement Agreement. The POI contained three examples of record reviews that had been completed using this template. Specifically, these consisted of the record reviews of Individual #203 (11/30/10); Individual #242 (11/30/10) by one of the Psychiatric Assistants; and an individual who resided on the Dolphin Residence (whose Facility number was not identifiable) by a Psychiatric Nurse on 11/19/10. The scoring legends for these reviews were as follows: N/A = not applicable; NS = not successful; PS = particularly successful; FS = fully successful. The individuals who were the subjects of these reviews were not selected in the random sample chosen for the current monitoring review. However, the inspection of these internal reviews indicated that they were generally consistent with the findings of the current reviews of the random sample. The internal reviews indicated an awareness of the lack of sufficient psychiatric consultation time to fully address the clinical needs of the individuals CCSSLC supported. The Monitoring Team's review of the random sample of 27 individuals' records would suggest that the Internal Reviews might have over-estimated compliance with the following sections of the Settlement Agreement: J.2, J.3, J.9, J.11, J.13, and J.14. The primary reasons for the discrepancies between the findings of the internal reviews and the review of the random sample discussed below are related to a focus, in the internal reviews, on whether a specific requirement was present or absent; whereas the Monitoring Team's

	review also assessed the quality of those factors. For example, the internal record reviews documented the presence of a psychiatric diagnosis and did not examine the degree to which that diagnosis could be supported by the identified symptoms. This observation also applied to the Risk versus Benefit Analysis and the related presence of the Human Rights approval and Informed Consent derived from those analyses. There was much closer concordance for those sections such as J.7 (Reiss Screen); J.12 (MOSES/DISCUS side effect screening); and J.15 (Documentation of communication between the Psychiatrist and Neurologist), which rely more heavily on a dichotomous yes/no assessment related to the presence of the required documentation. Despite the differences described above, the Facility's overall self-assessment of its compliance with the specific sub-sections of Section J of the Settlement Agreement related to Psychiatric Services was similar to that of the Monitoring Team. There were only two discrepancies between the Monitoring Team's assessment and the assessment of the Psychiatry Department contained in the POI. A notable exception was with regard to Section J.12, which relates to the monitoring for side effects with the MOSES and DISCUS Scales. The discrepancy between the Facility's self-assessment of substantial compliance and the Monitoring Team's findings of noncompliance, are discussed in detail in the report that follows. The possible reasons for the differing results also are discussed. The only other discrepancy was in regard to sub-section J.7, for which the Monitoring Team found evidence for substantial compliance, and the Facility's self-assessment indicated noncompliance. This is discussed further below with regard to Section J.7 of the Settlement Agreement. Thus, there was reasonable concordance between the Facility's overall self-assessment and the corresponding assessment of the Monitor. To bridge some of the gaps that were identified, attention should be paid to evaluating not only the presence of information, but also the quality of the supports provided.
	Summary of Monitor's Assessment: Although the Psychiatry Department at CCSSLC had definitely made progress in meeting some of the terms of the Settlement Agreement since the last review, a fundamental issue remained. The Facility relied on only 12 hours per week of psychiatric consultation time to manage the psychotropic medication for 144 individuals, some of whom had very complex psychiatric presentations. However, from a positive perspective, the Psychiatry Department had been able to accomplish a great deal through the diligent work of the two Psychiatric Assistants and the two Psychiatric Nurses at CCSSLC. The infrastructure they had created, and the ancillary services that they had provided, had made it possible to maximally utilize the limited amount of psychiatry time that was available. The Facility Medical Director indicated that, although the attempts to recruit additional Psychiatrists continued and had produced some responses, no viable candidates had yet been identified. A specific area that was noticeably improved was the documentation of the symptoms that supported an individual's psychiatric diagnosis. At the time of the last review, it was often impossible to locate any documentation of the specific symptoms that would have supported the identified psychiatric diagnosis in

	the individual's record, and, even when those symptoms could be located, they were not present in a cohesive manner. The Psychiatry Department had responded to this issue by implementing a system that listed the individual's primary symptoms that corresponded to the individual's identified psychiatric diagnosis. This list of symptoms appeared directly next to the relevant psychiatric diagnosis. This format not only provided the necessary information in a comprehensive manner that was easy to see, but also made it possible to carry the information forward from month to month and make changes as necessary. The intention was to have this information included in each of the Monthly and Quarterly Psychiatric Reviews. This information had not been carried over to the diagnostic section of the Comprehensive Psychiatric Assessments. Thus, although there continued to be deficiencies in the documentation of the individual psychiatric diagnosis, there had been considerable progress in correcting this deficiency. Another positive change had been in the documentation of the communication between the Consulting Neurologist and the Psychiatrist regarding individuals to whom they both provided services. The solution to this problem was to create a system that ensured that the Neurologist reviewed and commented on the most recent Psychiatric Consultation Notes. Each new Neurology Consultation also was discussed and commented on in the following Psychiatry Clinic and documented in the corresponding Notes. This innovation had only recently been implemented and, thus, was not reflected in all of the records reviewed. The Psychiatry Department, working in conjunction with the Psychology Department, also had made significant progress with regard to the section of the Settlement Agreement that related to the screening of individuals who did not receive psychotropic medication, to ascertain if they had any signs of undetected mental illness. Those individuals, who were identified as being in need of a mental health evaluation, were then referred for a formal Psychiatric Assessment. In addition, an initiative that involved Psychiatry, Psychology, Medicine, and the Pharmacy, had been established to ensure that the development of Pre-Treatment Sedation Medication Plans for medical and dental appointments were well thought out, with input from all of the above disciplines. This process, which had not been fully implemented at the time of the Monitoring Team's onsite review, was designed to take place at the beginning of the Psychiatric Clinics, to ensure that they occurred on a regular basis, and to maximize the efficiency of the staff involved. It also should be noted that this process applied only to the medications that were used for pre-treatment sedation. The responsibility for the development of the Desensitization Plans for medical and dental appointments had been consolidated within the Psychology Department. Although there had been progress since the last review, this process was still in the beginning stages of implementation. An area that continued to require additional attention was documentation to demonstrate empirically that the prescribed psychotropic medications were effective. This is especially relevant for those individuals who were receiving multiple psychotropic medications, as it becomes much more difficult to empirically demonstrate efficacy for individual medications, as the number of medications prescribed for a specific individual increases. The determination of the degree to which a specific medication has been helpful is also an integral factor in the risk-benefit analysis, as one cannot fully complete this analysis without having concrete data on both the efficacy of the medication, as well as the perceived and potential side effects of

	the medication. Another area that will continue to need attention is the identification of the linkage between the psychiatric diagnosis and the identified target behaviors of the prescribed psychotropic medications. Finally, an area requiring focused effort is the dual classification of behaviors as both targets of the psychotropic medication, and as being present on a learned basis or as a response to environmental factors. Thus, overall, it appeared that the Psychiatry Department had carefully reviewed the monitoring report and had implemented strategies to address a number of the recommendations.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	At the time of the review, Dr. Michael Hernandez, who was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, was CCSSLC's Consulting Psychiatrist. During the interview, which took place on 1/4/11, he indicated that, in addition to his consultation at CCSSLC, he also had provided psychiatric services to individuals with intellectual/developmental disabilities (ID/DD) through his private practice, as well as his work for a community provider of residential services. In addition, he had evaluated and treated outpatients with ID/DD through a local community mental health clinic. Dr. Hernandez estimated that he had provided psychiatric services to individuals with ID/DD for five years. He had been a psychiatric consultant to CCSSLC for approximately three and a half years. Thus, in addition to being Board Certified in Adult Psychiatry, he also had substantial clinical experience in working with this population and their unique needs. The Facility previously contracted with Ginari Price, M.D. At the time of the prior review, she was in the second year of her Child and Adolescent Psychiatry Fellowship at the Baylor College of Medicine in House, Texas. Over one weekend per month, she devoted approximately 16 hours to performing psychiatric evaluations at CCSSLC. Dr. Price completed her Child Psychiatry Fellowship last June and also terminated her work at CCSSLC at the same time. Since the last review, the Facility had employed two locum tenens temporary psychiatrists to provide limited amounts of time to perform Comprehensive Psychiatric Assessments. The Curriculum Vitae of these two individuals indicated that they had both completed Psychiatric Residency training programs. One of them was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. However, these individuals did not assume the actual treatment of any of the individuals who resided at CCSSLC.	Substantial Compliance
J2	Commencing within six months of	The Consulting Psychiatrist's time commitment to the CCSSLC consisted of three four-	Noncompliance

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	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.	hour blocks of time per week. He was present at the Facility for four hours on Tuesday and Wednesday mornings, and it was during these time periods that the Psychiatry Clinics took place. The third block of time, that he was present at CCSSLC, was on Friday afternoons. This time was allocated to psychiatric consultations, meetings with families/guardians as needed, and responding to urgent requests for psychiatric consultations outside of the Psychiatric Clinics. Two Psychiatric Nurses and two Psychiatric Assistants supported the Consulting Psychiatrist. The Clinical Nurses and Psychologists in the Residences also worked with the staff of the Psychiatry Department to schedule the Psychiatric Clinics and the direct observations of individuals by the Consulting Psychiatrist. The goal of the Psychiatry Department at CCSSLC was to have every individual, who was prescribed psychotropic medication, reviewed by the Psychiatrist on a monthly basis; and directly observed by the Psychiatrist during the quarterly reviews. A random sample of 29 individuals' records (20%), who were receiving psychotropic medication, was selected for purposes of this review, and the following sections of those records was requested: Face Sheet; Social History; Rights Assessment; Consents for Psychotropic Medication; Consents for Pre-Treatment Sedation Medication; HRC Referral Form and Addendums related to Psychotropic Medication; Behavioral Support section; Hospital section; Psychiatry section; Side Effect section; Pharmacy section; and the Neurology Consultation section. However, the complete records of two individuals could not be reproduced, because their Residences were under quarantine. The review of the remaining 27 records (19%) indicated that the goal of conducting both a Monthly and Quarterly Review in the Psychiatric Clinic was documented for all of those individuals whose records were reviewed. The corresponding goal to have every individual observed by the Psychiatrist at least quarterly was attained for 24 of these individuals (89%). Individual #237 was not available to be seen during the Quarterly Psychiatric Clinics of 4/20/10, 7/13/10, and 10/12/10. Documentation to indicate that the Consulting Psychiatrist observed this individual at an alternate time could not be located. In addition, Individual #323 was not available for the 11/2/10 quarterly review; and Individual #46 could not be seen at the 7/13/10 quarterly review. There was also no indication that these individuals were seen at alternate times. The review of this sample also indicated that there was a current Comprehensive Psychiatric Assessment (within the last 18 months) for all but Individual #10. Thus, a current Comprehensive Psychiatric Assessment was located for 26 of the 27 records reviewed (96%). This provision of the Settlement Agreement includes the qualification that the evaluation and diagnostic process will be conducted "in a clinically justifiable manner." Although	

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		the frequency of the reviews and observations was appropriate, the process, in and of itself, was not capable of producing the thorough psychiatric evaluation and diagnostic process that the Settlement Agreement requires. The report from the previous monitoring review commented on "a lack of the identification of the specific symptoms which supports the *DSM-IV-TR* Axis I and Axis II diagnoses." The Psychiatry team had responded to this observation and the related recommendation by implementing a significant change to the documentation that appeared in many of the Quarterly and Monthly Psychiatric Consultation Notes. That change involved the identification of symptoms the individual manifested that were related to the specific identified psychiatric diagnosis. This documentation appeared contiguous to each diagnosis. This process had only been implemented in recent months. Thus, it was not anticipated that this documentation would appear in all of the records reviewed in the random sample. The current review found that this documentation could be identified in the records of the following 13 individuals: Individual #58, Individual #230, Individual #237, Individual #323, Individual #202, Individual #46, Individual #172, Individual #327, Individual #49, Individual #141, Individual #136, Individual #305, and Individual #146. The specificity of this documentation varied considerably. The record of Individual #172 contained an exemplary discussion of the symptoms that supported the psychiatric diagnosis. This information was found in the CCSSLC Quarterly Psychiatric Review Note, dated 12/8/10, as indicated in the following excerpt from that document: *PSYCHIATRIC DIAGNOSIS* *Schizoaffective disorder (symptoms: psychosis, hallucinations, delusional thinking and behavioral disturbance); Obsessive compulsive disorder (symptoms: obsessive over particular items or subject matters and anxiety associated with these beliefs); Generalized anxiety disorder (symptoms: exhibits irritability, anxiety, poor concentration and insomnia), Major depressive disorder, recurrent, severe with psychotic features (d/c [discontinued] 12/8/10); Borderline personality disorder (symptoms: rejection sensitive, unstable interpersonal relationship, engaged in all or nothing thinking).* The symptoms were further elaborated on in the following section of this Review: *PSYCHIATRIST'S RECOMMENDATIONS AND/OR MEDICATION CHANGE* *He will continue with Klonopin 0.5 mg [milligrams] bid [twice a day], Fanapt 6 mg bid, Tenex 1 mg qid [four times a day] and Pristiq 50 mg q [each] daily.*	

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		He does have a history of Schizoaffective disorder consisting of symptoms of psychosis, hallucinations and delusional thinking as well as behavioral disturbance. In addition he has exhibited mood components including depressed mood, anhedonia, easy agitation, poor impulse control, and mood instability. In addition, he exhibits irritability, anxiety, poor concentration, and insomnia consistent with generalized anxiety disorder. He also is rejection sensitive, has unstable interpersonal relationships, and engages in all or nothing thinking consistent with Borderline Personality Disorder. He does remain obsessive over particular items or subject matters, and does have anxiety associated with these beliefs and has been diagnosed with Obsessive Compulsive Disorder. Another example of a reasonable discussion of the symptoms that supported the psychiatric diagnosis appeared in the record of Individual #18. The CCSSLC Monthly Psychiatric Review, dated 11/10/11 listed only the following psychiatric diagnosis: *Psychiatric Diagnosis: Major Depressive Disorder, single episode, Moderate and Intermittent Explosive Disorder [IED].* However, the following section from the same Review contained a discussion of the relevant symptoms: *Psychiatrist's Recommendations and/or Medication Change: She does have a h/o [history of] crying spells, depressed mood, social isolation, anhedonia & has been diagnosed c [with] Major Depressive Disorder, Recurrent, Moderate. She previously has been diagnosed with IED. We did review her present symptoms. She does not exhibit any present symptoms suggestive of this diagnosis. Subsequently, the diagnosis of IED will be removed. She will continue with Lexapro 40 mg q.a.m. Will follow up in December. [Signed by Psychiatrist]* None of this documentation was extensive enough to fully substantiate the related psychiatric diagnosis in terms of all of the symptoms that would be required to fulfill the complete Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*DSM-IV-TR)* diagnostic criteria, nor would it meet the quality standards inherent in the Settlement Agreement. The example of Individual #172 is cited here as it contained more information than was present in other records. The addition of this extensive documentation would be more appropriately contained in the Comprehensive Psychiatric Assessments. This could include the first three axes of the DSM IV multi axial system or a discussion of the related Diagnosis based on DM-ID criteria, if that system is more appropriate for the individual. This also would be the most appropriate place to describe the "specific behavioral-pharmacological hypothesis" that provides the rationale for the psychotropic medication for those individuals for whom the justification is not derived from the standard psychiatric nosology. This more complete discussion in the relevant section of the Comprehensive Psychiatric Assessment would meet the	

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		criteria set forth in the Settlement Agreement and would also augment the briefer listing of symptoms that is carried forward in the Quarterly and Monthly Psychiatric notes. A corresponding description of the symptoms that would support the identified psychiatric diagnosis could not be identified in the Comprehensive Psychiatric Assessment section of any of the records reviewed for the random sample. A related issue, which also was identified in the prior review, concerned the lack of documentation that would explain how the identified target behaviors (usually aggression, agitation, and/or self-injury) were derived from the psychiatric diagnosis. The review of the relevant records and discussions with the members of the Psychiatry Department indicated that this linkage in the psychiatric diagnostic process had not yet been addressed. The documentation of this linkage would also be appropriate for discussion in the Comprehensive Psychiatric Assessments. The prior monitoring report also discussed the identification of behaviors that are designated as "targets" of the psychotropic medication, and are also being described in the Functional Analysis and Behavioral Support Plans as being present on a learned and/or environmental basis. Discussions with members of the Psychiatry Department indicated that collaboration with the Psychology Department had begun around this issue. However, the review of the records contained in the random sample indicated that this dual classification of behaviors as both targets of the psychotropic medication, and as being present on a behavioral basis, still remained problematic. Specifically, this dual classification of behaviors was found in the records of 21 individuals (78%). The records for the following individuals did not contain this dual classification were: Individual #52, Individual #10, Individual #255, Individual #230, Individual #323, and Individual #308. This issue also will be further discussed below with regard to Section J.13 of the Settlement Agreement. The justification for the dual classification of a behavior would also be suitable for the Comprehensive Psychiatric Assessment. Thus, although a Comprehensive Psychiatric Assessment appeared in 96% of the random sample, they did not fully meet the quality requirements of the Settlement Agreement. This finding should not be construed as an indication that the Comprehensive Psychiatric Assessments reviewed were of no value. The documents reviewed contained significant amounts of relevant clinical information. The addition of the information referred to above should enhance their utility, and can be added as the Comprehensive Psychiatric Assessments are updated.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for	There was no indication that psychotropic medication was utilized at CCSSLC as a punishment, or for the convenience of the staff. All of the individuals included in the sample, who received psychotropic medication, had a treatment program and one or more psychiatric diagnoses. However, as discussed above, documentation was not extensive enough to fully substantiate the related psychiatric diagnosis in terms of all of	Noncompliance

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	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.	the symptoms that would be required to fulfill the complete *DSM-IV-TR* diagnostic criteria. In addition, the dual classification of behaviors, as being present on a learned basis and/or secondary to environmental factors, as well as being identified as targets of psychotropic medication, created the impression that psychotropic medications were being utilized to suppress behaviors that would more appropriately have been addressed with non-pharmacological approaches.	
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 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.	During the interview with members of the Psychology Department on 1/4/11, it was noted that Desensitization Treatment Plans for medical and dental appointments had been developed for a number of individuals, but that these were in the beginning stages of implementation. The Rights/Consents section of each individual's record indicated whether or not an individual required pre-treatment sedation for medical and/or dental appointments. The review of the random sample found that 14 individuals were identified as not requiring pre-treatment sedation. Desensitization Plans could be located in the records of only two (Individual #138 and Individual #153) of the 13 remaining individuals (15%). Concerns related to the Desensitization Plans that had been developed shortly before the Monitoring Team's onsite visit are detailed with regard to Section C.4 and Section S of the Settlement Agreement. Signed Consents were identified for all of the individuals who received pre-treatment sedation medication for medical and/or dental appointments. A new initiative that related to this section of the Settlement Agreement was the establishment of a multi-disciplinary process to ensure the appropriateness and safety of medications that were prescribed for sedation prior to medical and dental appointments. This process reportedly would include direct input from the Psychiatrist, the Psychiatric Nurse, the Unit Nurse, the Primary Care Physician, the Psychologist, and the Clinical Pharm.D. These reviews were scheduled to occur at the beginning of the Psychiatric Clinics, because all of the disciplines identified above routinely participated, with the exception of the Clinical Pharm.D. However, since these meetings had not yet taken place, no documentation appeared in the review of the random sample of the medical records. The meetings were expected to begin during the next review cycle.	Noncompliance
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	The initial review of psychiatric services at CCSSLC indicated that two full-time Psychiatrists (or the equivalent amount of Consulting Psychiatrists) would be required to adequately evaluate and provide psychiatric services to the individuals who reside there. This would equate to a caseload of approximately 75 individuals for each Psychiatrist. Many of the individuals who reside at the CCSSLC present with complex psychiatric disorders and the current utilization rates of multiple psychotropic agents for numerous individuals would suggest that this is a reasonable estimate.	Noncompliance

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	necessary for implementation of this section of the Agreement.	The Facility was relying on one part-time Consulting Psychiatrist to provide the day-to-day psychiatric care to all of the 144 individuals who were receiving psychotropic medication. His allotment of time was 12 hours per week (three four-hour blocks per week), which was slightly more than 25 percent of one full-time equivalent Psychiatrist. An additional Psychiatrist had been providing approximately 16 hours of consultation time over one weekend per month, and was primarily devoted to performing Comprehensive Psychiatric Assessments. When this Psychiatrist completed her Child Psychiatry Fellowship at the Baylor College of Medicine in June of 2010, she also terminated her work at CCSSLC. The Facility had utilized two locum tenens temporary Psychiatrists since the last review to continue the work on completing the Comprehensive Psychiatric Assessments. During the interview on 1/5/11 with the Facility's Medical Director, she described the efforts that CCSSLC had undertaken to recruit additional psychiatrists, which had included an increase in salary, networking with local physicians, and advertising in national publications, such as the *Psychiatric Times*, and *Career Builders*. Thus, the Facility's administration had been making an active, sustained effort to address this deficiency, but had not yet been successful.	
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.	One Psychiatrist, who worked on a contractual basis, provided psychiatry services at the CCSSLC. The primary contact that the Psychiatrist had with the individuals and their teams took place in the context of the Monthly and Quarterly Psychiatric Clinics. The monthly meetings, including the quarterly reviews, occurred as scheduled. As discussed with regard to Section J.2 of the Settlement Agreement, evidence that the Psychiatrist observed the individual at the quarterly Meeting was documented for 89% of the random sample of 27 individual records. The Psychiatric Nurses, Psychiatric Assistants, and the Residential Nursing Staff, working in conjunction with the members of the Psychology Staff, contributed to the successful execution of this schedule of Psychiatric Clinic reviews. As noted with regard to Section J.2, the monthly and quarterly reviews of psychotropic medication took place as scheduled. The quarterly observations of the individuals by the Psychiatrist were documented for all but three individuals in the random sample. Current Psychiatric Assessments were identified in 26 of the 27 records reviewed (96%). Deficiencies related to both the documentation of the Psychiatry Clinics and the Psychiatric Assessments are described in more detail with regard to Sections J.2 and J.13. The Psychiatric Assessments did not contain reference to all of the Headings and Sub-Headings that were identified in the outline contained in Appendix B of the Settlement Agreement. As the Comprehensive Psychiatric Assessments are updated it would be useful to review the prototype that is contained in the Settlement Agreement. Specific	Noncompliance

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		missing documentation directly related to this provision of the Settlement Agreement included the information that would link the monitored behavior, such as aggression, agitation, and/or self-injurious behavior, to the psychiatric diagnosis of record, as well as empirical data that would substantiate that the psychotropic medication had been effective. The latter point is important, in that this information is necessary in documenting that the benefits of the medication(s) outweigh the risk that they present, based on their side effect profile(s).	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Department of Psychiatry at the CCSSLC implemented their first series of Reiss Screens in August of 2009. This process involved the screening of individuals who were not receiving psychotropic medication. The protocols were then processed through the appropriate computer software program and the individuals who were identified as requiring a Psychiatric Evaluation were referred to the Consulting Psychiatrist for a consultation. The second round of implementation of the Reiss Screen was begun in July 2010. During the Monitoring Team's January 2011 onsite review, a spreadsheet was requested that included the names of the individuals who were administered the Reiss Screen and the dates of administration. The spreadsheet indicated that the Reiss Screen had been administered to 140 individuals. The CCSSLC census at the time of the onsite review was 283 individuals, of which 144 were receiving psychotropic medication and, thus, would have undergone a formal Psychiatric Assessment as part of that process. The combined total of 284 exceeded the current census of 283, due to discharges and deaths that had occurred since the Reiss Screens were administered in July 2010. The spreadsheet would suggest that the Reiss Screen was completed for all of the individuals who were not receiving psychotropic medication. In order to assess the accuracy of the data contained in the spreadsheet, a random sample of 20% of the individuals who had been evaluated with the Reiss Screening instrument was identified, and a copy of the Reiss Screening instrument and computer scoring was requested. This request produced the following random sample of individuals who were identified as having been administered the Reiss Screen for Maladaptive Behavior Version 1.1 and the dates of administration: Individual #48, 7/5/10; Individual #339, 7/9/10, with a note stating: "[Individual #339] exhibits behaviors that may indicate a need for mental health supports. Please arrange for professional evaluations to better determine this individual's needs"; Individual #126, 7/16/10; Individual #205, 7/16/10; Individual #24, 7/16/10; Individual #222, 7/16/10; Individual #113, 7/16/10; Individual #393, 7/16/10; Individual #32, 7/16/10; Individual #15, 7/16/10; Individual #366, 7/16/10; Individual #179, 7/16/10; Individual #270, 7/16/10; Individual #166, 7/16/10; Individual #327, 7/21/10; Individual #37, 7/16/10; Individual #206, 7/5/10, with a note stating: "[Individual #206] exhibits behaviors that may indicate a need for mental health supports. Please arrange for professional evaluations to better determine this	Substantial Compliance

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		individual's needs"; Individual #187, 7/19/10, Individual #208, 7/20/10, with a note stating: "[Individual #208] exhibits behaviors that may indicate a need for mental health supports. Please arrange for professional evaluations to better determine this individual's needs"; Individual #65, 7/9/10; Individual #207, 7/9/10; Individual #182, 7/9/10; Individual #102, 7/9/10; Individual #31, 7/7/10; Individual #86, 7/20/10; Individual #215, 7/20/10; Individual #276, 7/22/10; and Individual #99, 7/21/10. As noted above, the computer scoring for Individual #339, Individual #206, and Individual #208 indicated that their scores on the Reiss Screen were above the threshold that would prompt a formal psychiatric evaluation. In order to ascertain if these assessments were carried out, the related Psychiatric Consultations that would have been performed by the Psychiatrist were requested and verified, indicating adherence to this aspect of the Settlement Agreement. The specific data related to this finding are as follows: ▪ Individual #206's date of elevated Reiss Score was 7/5/10. The psychiatric evaluation for Individual #206 was not dated. However, based on Individual #206's birthdate and the age listed in the psychiatric assessment, it is likely that it was performed after the elevated Reiss Score was obtained on 7/5/10; ▪ Individual #339's date of elevated Reiss Score was 7/9/10, and the date of the psychiatric evaluation precipitated by elevated Reiss Score was 7/27/10; and ▪ Individual #208's date of elevated Reiss Score was 7/20/10, and the date of psychiatric evaluation precipitated by elevated Reiss Score was 8/20/10. These findings would indicate that the Facility had developed an effective mechanism for ensuring that individuals who were not receiving psychotropic medication were evaluated with the Reiss Screen and further, that those individuals who were identified as requiring follow-up psychiatric assessment were evaluated by the Psychiatrist in a timely manner. The Facility's self-assessment indicated noncompliance for this section. The extensive review of the relevant documentation carried out as part of this review indicated that the Reiss Screens had been completed as required in the Settlement Agreement and the Psychiatric Consultations precipitated by elevated scores on the Reiss Screen were performed in a timely manner. The methodology utilized by the Psychiatry Department to conduct and respond to these assessments was discussed during the onsite review, and there was no indication of deficiencies. In their self-assessment notes, the Facility's narrative related to this subject indicated that the Reiss Screen was to be performed on new admissions, and that CCSSLC had not	

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		had any new admissions in some time. Thus, it is possible that this was construed as constituting noncompliance. This issue will be discussed with the Psychiatry Department at the next review.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The Consulting Psychiatrist worked closely with the members of the Psychology Department. This was evident at the 1/4/11 and 1/5/11 Psychiatric Clinics. The Psychologist who was responsible for the individual being reviewed led the presentation and discussed the Behavioral Data for the month. It was clear that the Psychiatrist relied on this information when making decisions regarding the use of psychotropic medication. Within the sample of individual records reviewed, it was evident that each individual who was prescribed psychotropic medication had an active, Positive Behavioral Support Plan. However, there were deficiencies in the integration of the psychiatric and psychological perspectives on the individual. In the records reviewed, the symptoms that were described as being "targets" of psychotropic medication were also frequently (as discussed with regard to Section J.2, for 78% of the individuals in the sample) described in the Functional Analysis as being present on an operant basis, as a response to a demand situation, representing an escape behavior, or being related to environmental, stressful events. It is conceivable that the symptoms of a psychiatric disorder could be affected by these factors, but the documentation necessary to support such a connection was not present. The available documentation indicated that the psychiatric assessment process and the psychological assessment process were operating in a parallel manner and were not integrated. The documentation also gave the impression that the psychotropic medication was being prescribed to treat "target behaviors" such as "aggression," "agitation," and/or "self-injurious behavior (SIB)," rather than the symptoms of an identified psychiatric disorder. The integration of psychiatric services with psychological services at CCSSLC could be improved by the integration of the Treatment Plans for the use of psychotropic medications with the Behavioral Support Plan, so that it is clear which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies. For those individuals for whom the identified behavior is thought to be determined by both biological and psychological processes, this should be clarified with adequate justification provided to show the connections between each.	Noncompliance
J9	Commencing within six months of the Effective Date hereof and with full implementation within two	This provision describes a collaborative process through which, "the Interdisciplinary Team, including the Psychiatrist," shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition.	Noncompliance

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	years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	There was no documentation in the records reviewed that this collaborative process was occurring at the CCSSLC. The Psychiatric Clinics were attended by multiple disciplines, including the primary care practitioner (PCP), Nursing, direct support professionals, Psychology, and QMRPs. The composition of the disciplines that attended the Psychiatric Clinics qualified as an Interdisciplinary Team (IDT). The topic of the discussions at these Clinics was primarily focused on the effects of prescribed medications, as determined by the frequency of the monitored target behaviors, which were presented by the Psychologist. The discussion also included the subjective impressions of other team members, as well as the description by the nursing staff of any medication side effects. There was very little discussion of alternate treatment approaches, other than those related to the psychotropic medications, although there was discussion of environmental factors and/or changes in physical status that may have adversely affected the frequency of the monitored behaviors. The Psychiatrist clearly took this information into account when making decisions. There was no evidence in the 27 records reviewed that there was a multi-disciplinary process to determine if psychotropic medication was the "least intrusive" approach to the individual's presentation before the pharmacological approach was chosen over a less intrusive behavioral approach. The lack of this integration was likely affected by the Facility's reliance on 12 hours of psychiatric consultation time to manage the psychotropic medication of 144 individuals, many of whom presented with complex psychiatric presentations. To a certain extent, this allocation of time limited the focus of the Psychiatrist and the Interdisciplinary Team to the most pressing clinical considerations related to psychotropic medications. The discussion above, with regard to Section J.8 of the Settlement Agreement concerning the lack of integration of psychiatric and psychological services, was also relevant to this provision, as is the discussion below with regard to Section J.13.	
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	This provision discusses the importance of carefully assessing the benefits of the utilization of specific psychotropic agents against the risks posed by the side effects of those medications. The primary documentation of this process appeared in the Human Rights section of individuals' record. This documentation consisted of limited information related to the extent that the benefits of the medication outweighed the risks. Also included was a listing of the most commonly known side effects of the medication, without any indication of the likelihood of these side effects occurring, based on the published literature. These observations applied to all of the records reviewed and represented inherent deficiencies in the Risk versus Benefit Assessment process. This was not a case of isolated examples of incomplete documentation.	Noncompliance

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	harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	An example of this process is illustrated in the following excerpt taken from the "HRC Referral Form," dated 10/13/10, concerning Individual #19: *Brief description of restriction: Updated PBSP with medications for behavior management. Klonopin for aggression 1 mg bid, 2mg at hs [at night] and Zyprexa for agitation 30mg @ hs.* *Reason for restriction: [Individual #19's] program was developed to help decrease his challenging behavior of agitation. His challenging behavior of agitation can result in some aggressive behavior and his medications are greatly reduced by the use of his medications. Without his medications his agitation would be of greater intensity and greater risk for injury.* *Risk vs. risk analysis: The PST believes no restriction outweighs the risks of the use of psychotropic medications (sic). Some possible side effects are constipation; dizziness or fainting when getting up suddenly from a lying or sitting position; drowsiness; dryness of mouth; headache; insomnia; impotence, reduced sexual ability, desire, drive or performance, heartburn, gas in stomach.* *Less intrusive approaches previously attempted: His program consists of a training objective and the use of verbal and physical redirection to other more appropriate activities. These interventions are not as effective without the use of medications.* *Plan to remove restriction: His medications are reviewed monthly and compared to his challenging behavior. Reductions are considered based on progress. On his current medication he is doing much better. Once he begins to meet these objectives the PST considers this progress and will recommend a reduction in his medications.* *Review date: 10/14/11* *Input from the correspondent/guardian: Mother agreed and signed a consent form.* *Input from the person: [Individual #19] did not respond to the questions but did reach out and grabbed my arm.* A similar example was contained in the "HRC Review of BSP," dated 1/14/10, for Individual #281: *BSP Information: (to be completed by Psychologist)* *Program description (to include restrictive/intrusive components): BSP to address Autistic Related behaviors and Roaming Behaviors. [Individual #281's] primary restrictions are his*	

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		medications: Cymbalta 30 mg Bid, Klonopin 1 mg Tid [three times a day], Seroquel 1600 mg daily, and Namenda 10 mg Bid. Less intrusive approaches previously attempted: Counselling, redirection, environmental restructure, reinforcement, sensory changes. *Risk vs. Risk Analysis: [Individual #281] has a history of throwing large pieces of furniture, head banging, and biting others and himself. He has hurt himself and others in the past. There have been no side effects witnessed from his medications. His risk of injuries outweighs the other possible risks.* *Plan to remove restriction/intrusive component: Instead of <u>Autism Related Behaviors</u>, [Individual #281] will <u>learn how to sign for pain</u> 20/30 daily trials, per month for six consecutive months, by 1/31/11. Instead of <u>Roaming Behaviors</u>, [he] will <u>Participate in outside activities</u> for 20/30 daily trials per month for six consecutive months, by 1/31/11.* The following risk versus benefit discussion, which appeared in the "HRC Referral Form," dated 4/23/10, for Individual #305, contained somewhat more information concerning the actual perceived benefits of the medication, as well as the risks: *MEETING: Review of Rights Restrictions* *<u>Brief description of restriction</u>: [Individual #305's] restrictions are psychotropic medications which include: Lexapro 40 mg q a.m. and a rear buckling seat belt.* *<u>Reason for restriction</u>: [Individual #305's] Behavior Support Program addresses the Challenging Behavior of Self-Injurious Behavior. [His] use of medication allows [him] to function in his environment without restrictive levels of supervision and without restrictions on his freedom of movement. His quality of life does not seem to be negatively affected and improving his behavior allows for more positive interactions with others in his environment. [He] utilizes a rear buckling seat belt as a protective restraint.* *<u>Risk vs. risk analysis</u>: Risk of injury due to skin breakdown is greater than the risks posed by his medication. Medical staff routinely monitor for side effects of the medication.* *<u>Lexipro</u>: (Escitalopram) Constipation; diarrhea; dizziness; nausea; dry mouth; increased sweating; ejaculation delay; gas in stomach; heartburn; inability to have or keep an erection; impotence; loss in sexual ability, desire, drive, or performance; stomach pain; insomnia; trouble sleeping; unable to sleep; decreased interest in sexual intercourse; sleepiness or unusual drowsiness.* *<u>Less intrusive approaches previously attempted</u>: Redirection is used and replacement behaviors of providing [Individual #305] with activities of his choice. Environmental*	

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		restructuring is useful because crowded environments agitate [him]. He is on a low dosage of medication which has been reduced from previous dosages as he has made progress with the aforementioned. *Plan to remove restriction: [Individual #305's] response to drugs for behavior management will be evaluated at least monthly at Psychiatry Clinic. Consideration will be given to reducing or discontinuing the medication at least annually, unless contraindicated. Documentation on reduction and/or contraindications will be included in Consulting Psychiatrist's monthly consultation notes.* *Review date: Reviewed by the PST at Monthly Meeting or as needed and at Monthly Psychiatric Clinic.* *Input from the correspondent/guardian: [Individual #305's] brother is his legal guardian and is agreeable to the medication that assists [him] with his self-injurious behavior and to the rear buckling seatbelt as a protective restraint.* *Input from the person: Non-verbal* The Human Rights review of the psychotropic medication also addressed an individual's entire regimen of psychotropic medication, rather than discussing each individual medication separately. The rationale for this policy was the perception that the prescribed psychotropic medications constituted a Medication Treatment Plan. This policy obfuscated the risk inherent in the utilization of each medication. It also impeded the ability to assess a specific medication's efficacy, which is a factor that is central to the Risk versus Benefit Analysis. This was an area in which the Facility had made little progress and required focused attention. A finding of noncompliance was made due to the inadequacy of the risk versus benefit information included in the records of the individuals reviewed, as well as the failure of the system to separate out each medication from the overall medication regimen.	
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	The CCSSLC had developed a Polypharmacy Committee that met monthly to review those individuals whose psychotropic medication profiles were consistent with the definitions of polypharmacy. The meeting was referred to as the Monthly Psychiatric Services Review (PSR). Minutes of these meetings were available for the last six months (most recent meeting held on 12/28/10). The following excerpt from those minutes lists the individuals who would typically attend this meeting: Primary Facilitator(s): Psychiatric Assistant	Noncompliance

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	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.	Participants: Psychiatrist Psychiatric Assistant Clinical Psychologist Clinical Pharmacist Psychiatric RN QMRP Coordinator M.D., PCP The minutes of the meeting were prepared by a Psychiatric Assistant, and consisted of approximately six-to-eight single-spaced pages. It was clear from these documents that detailed, case-based discussions took place during the meetings. The final section of the minutes also contained a review of the Psychiatry Department's efforts and current progress with regard to meeting the provisions of the Settlement Agreement related to polypharmacy. The identified goal of this process "is to ensure that the use of such medications is clinically justified and that medications that are not clinically justified are eliminated." The clinical justification of the use of multiple medications for the individuals who reside at the CCSSLC will be difficult to document without fundamental changes in the existing data-collection systems that are described below with regard to Section J.13 of the Settlement Agreement. In response to a recommendation made in the prior monitoring report, the Psychiatry Department had begun to incorporate longitudinal data into the content of the monthly minutes of the Polypharmacy Committee Meetings. This statistical data indicated that, as of the 12/28/10 Meeting, 144 individuals were receiving psychotropic medication. The distribution with regard to the number of individuals who were prescribed multiple psychotropic medications was as follows (Note: the numbers in the columns total 143 individuals, not 144. These numbers were taken from the original documentation the Facility provided): Number of Psychotropic Medications — Number and Percentage of Individuals One — 32 (22.1%) Two — 27 (18.8%) Three — 41 (28.4%) Four — 21 (14.5%) Five — 15 (10.4%) Six — 4 (2.6%) Seven — 3 (2.1%)	

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		These frequencies represent incremental, sustained progress from those reported in the prior monitoring report. That review indicated that the following data was contained in the 6/24/10 minutes of the monthly Psychiatric Services Review: Number of Psychotropic <u>Medications</u> — Number and Percentage of <u>Individuals</u> One or Two — 61 (40%) Three — 51 (34%) Four — 20 (13%) Five — 11 (7%) Six — 7 (4%) Seven — 0 Eight — 1 (less than 1%) This data will provide important benchmarks for assessing the Facility's progress in reducing polypharmacy in the future. In order for the Facility to achieve compliance with this provision of the Settlement Agreement, clinical justification of the use of multiple medications for the individuals who reside at the CCSSLC will need to be improved, as described below with regard to Section J.13 of the Settlement Agreement.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The policy at the CCSSLC was to administer the Monitoring of Side Effects Scale on a quarterly basis for all individuals receiving psychotropic medication. A Psychiatric Nurse administered these evaluations. To assess for compliance, this review of psychiatric services utilized a random sample of 27 of the individuals at the CCSSLC who were receiving psychotropic medication (19%). A review of the medical records for those individuals contained documentation that a MOSES evaluation had been performed on a quarterly basis over the last year, and was current for all but the following individuals: Individual #52, Individual #133, Individual #327, Individual #296, Individual #308, and Individual #153. Thus, 78% of the sample met this provision of the Settlement Agreement. A Psychiatric Nurse also performed the Dyskinesia Identification System: Condensed User Scale on a quarterly basis for all of the individuals who receive antipsychotic medication. Review of the random sample indicated that documentation of current and quarterly evaluations for the last year could be identified for the entire sample, except for Individual #296, Individual #308, Individual #18, Individual #153, Individual #52, Individual #133, and Individual #327. Thus, 74% of the sample met these criteria.	Noncompliance

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		The DISCUS was also performed at CCSSLC for those individuals who received Reglan. The rationale for this is that, although Reglan is used to treat severe Gastroesophageal Reflux Disease (GERD), it also has dopamine-blocking properties that are similar to those of some of the antipsychotic agents and can, thus, also produce extrapyramidal motor side effects. The Clinical Nurses in the residences performed the DISCUS for those individuals. The sample for this analysis was constructed by obtaining a list of all individuals who were prescribed Reglan from the pharmacy. The individuals who also received psychotropic medication were deleted, and a copy of the DISCUS for the last year was requested for every fourth remaining individual (25%). This process produced the names of the following five individuals: Individual #15, Individual #239, Individual #43, Individual #113, and Individual #195. The documentation provided by CCSSLC in response to this request indicated that the DISCUS had been completed quarterly, and was current for three of the five individuals (60%). Those individuals were: Individual #239, Individual #43, and Individual #195. The same sample was also reviewed for the completion of the MOSES Side Effect Evaluation. This review indicated that the MOSES had been completed quarterly and was current for 100% of the sample of individuals who were receiving Reglan. The Facility Self-Assessment prepared by the Psychiatry Department indicated that they believed they were in substantial compliance with this provision of the Settlement Agreement. The data presented above, as well as in the prior review, indicate that the MOSES and DISCUS were being completed on schedule for the majority of the individuals for whom they are required, but not to a degree that would constitute compliance with this provision of the Settlement Agreement. This observation, coupled with the Facility's perception that they have achieved compliance, could indicate either a flaw in the scheduling process and/or a clerical error in the filing of the documents in the individuals' records. The Psychiatry Department might find it useful to ascertain if one or both of these issues could be related to the finding that although there are relatively high rates of completion of these instruments, significant deficits remained in the completion rate.	
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	This provision of the Settlement Agreement addresses three significant inter-related factors that are central to the appropriate use of psychotropic medication for individuals with ID/DD. These factors include: 1) the documentation of the validity of the psychiatric diagnosis; 2) the relationship of that diagnosis to the behaviors that are identified as targets of the psychotropic medication; and 3) the objective documentation that the medication has been effective for the disorder for which it was prescribed. In order to assess these three factors, a random sample (20%) of individuals was chosen by	Noncompliance

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	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.	selecting every fifth individual who received psychotropic medication. The sections of the records for the above individuals that were requested are as follows: Face Sheet; Social History; Rights Assessment; HRC Referral Form with Addendums related to psychotropic medication; Psychiatry Section; Behavioral Supports section; Consents for Psychotropic Medication; Consents for pre-treatment sedation medication; Neurology Consultations, if present; Pharmacy section; Side Effect section; and External Hospitalization section, if present. As indicated above with regard to Section J.2, the records of two individuals were incomplete and, thus, were not considered in the review. Their residences, which contained significant sections of their records, were under quarantine at the time of the onsite review. This resulted in a sample of 27 individuals (19%) of those receiving psychotropic medication. At the time of the prior review, a significant finding was the inability to locate documentation in the records that would describe the presence of the symptoms necessary to support the psychiatric diagnosis of record. The Psychiatry Department responded to the recommendations related to this finding by developing a system that identified the symptoms related to a psychiatric diagnosis next to that diagnosis in both the monthly and quarterly Psychiatric Clinic Notes. The number of symptoms listed varied between diagnoses and there were records in the random sample in which evidence of this relatively new procedure could not be located. There were also instances where the listing of symptoms was brief and cursory. However, all over, this represented a positive response to the previously identified deficiency. The current review found that adequate symptomatic support for the psychiatric diagnoses could be identified in 13 of the 27 records reviewed (48%), as compared to 41% at the time of the prior review. However, this incremental improvement did not fully reflect the significance of this positive change. At the time of the prior review, the substantiation of the symptoms that would support the psychiatric diagnoses was often located in various sections of the record and was not present in a cohesive manner. In addition, the current review indicated that the new methodology had not been implemented yet in the records of all individuals. (This finding is also discussed with regard to Section J.2, as it relates to both sections of the Settlement Agreement.) A related issue in the prior review was the lack of documentation linking the monitored target behavior to the identified symptoms of the psychiatric disorder. The primary behaviors monitored to assess the efficacy of psychotropic medication at the CCSSLC were aggression, self-injurious behavior (SIB), and agitation. The documentation in the records that provided the linkage between the psychiatric diagnosis and the occurrence of these behaviors was either lacking or insufficient in the entire sample reviewed. The discussion of this linkage would be an appropriate issue to review in the Comprehensive Psychiatric Assessments.	

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		As noted above with regard to Sections J.2 and J.8, these behaviors (aggression, self-injurious behavior, and agitation) were also often identified in the Functional Analysis and Behavioral Support Plan as being present on a learned-behavioral basis, representing a response to demand situations, and/or were used by the individual to escape or avoid a situation. During the discussions with members of the Psychiatry Department, they indicated that there had been initial collaboration with the Psychology Department concerning this issue. The dual identification of the behavior as being both a target of the psychotropic medication(s) and being present on a behavioral basis was consistent throughout the study sample in the prior review. The current review found adequate differentiation between behaviors that were identified as targets of psychotropic medication and those that were thought to be present on a learned/environmental basis in the records of the following six individuals (22%): Individual #52, Individual #10, Individual #255, Individual #230, Individual #323, and Individual #308. For example, the Psychiatric Clinic Notes for Individual #52 clearly indicated that the psychotropic medications were prescribed for symptoms of a psychotic disorder. As indicated by the following sections taken from the 11/2/10 Monthly Psychiatric Review: *Medication* / *Rationale/symptoms* / *Start Date* *1. Abilify* / *Schizoaffective disorder* / *11/12/05* *2. Depakene* / *Schizoaffective disorder* / *11/11/05* *Behavior Services* *Challenging Behaviors: Disorganized Speech/Thoughts related to Schizophrenic Disorder; defined as not being able to respond to questions appropriately, not following topic of conversations, talking about past experiences or delusional situations and talking to himself.* *Replacement Behaviors* *By December 31, 2010, [Individual #52] will identify at least three (3) reality-based items from his environment daily for 25 out of 30 days for 6 consecutive months.* The Positive Behavioral Support Plan for Individual #308, dated 8/19/09, also clearly indicated that the psychotropic medication was prescribed to address the symptoms of a psychiatric disorder, as indicated by the following excerpt: *RELATIONSHIP OF PBSP & FUNDAMENTAL OUTCOMES* *What supports does [Individual #308] need to enhance his life? (PSP Action Step Outcome)*	

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		[Individual #308] requires a great deal (sic) verbal prompts as he is actively psychotic. He is able to answer simple questions but will then make statements that are not relevant to the question or his current situation. He is diagnosed with Schizophrenia, Paranoid Type. He is also taking Psychoactive medication. Currently, he has no restrictive measures in Positive Behavior Support Plan other than his medications. Since his admission to the Corpus Christi State Supported Living Center we have seen a variety of Challenging Behaviors such as Physical Aggression, Verbal Aggression, Program Refusal. It appears that these behaviors are related to his diagnosis as he is often unaware that some of his statements create conflict with his peers. Nevertheless, staff report improvement with cooperation since his admission to the CCSSLC. An example of an individual who was prescribed psychotropic medication for behaviors that were also described as being related to environmental and interpersonal stressors, was contained in the documentation related to Individual #296. The Positive Behavioral Support Plan dated 3/3/0/10, described the precipitants of his aggressive behavior as follows: *REPLACEMENT BEHAVIORS* *Challenging Behavior 1: Aggression – defined as attempts to hit and or hit others with a closed fist, back hand slap and or pushing others.* *By 3/31/11, [Individual #296] will learn to express his needs verbally daily, 20/30 daily trials for 6 consecutive months. (Continue this objective.)* *Teaching Rationale: [Individual #296] will display aggression when he feels frustrated (i.e. too many prompts, demands) or when he feels someone has invaded his personal space by sitting too close to him. If [he] can learn to express his needs with words other than with aggression, this will increase communication skills and decrease aggression towards others.* However, the Psychiatric Clinic Notes indicated that the aggression was related to an Intermittent Explosive Disorder, as illustrated in the following excerpt: *Psychiatric Diagnosis: Intermittent explosive disorder (aggression, anger out of proportion to situation.)* And, he was prescribed the following psychotropic medications for this diagnosis: *<u>Medication</u> — <u>Rationale/symptoms</u> — <u>Start Date</u>* *1. Seroquel — Intermittent Explosive Disorder — 11/11/05* *2. Tegretol — Intermittent Explosive Disorder — 11/11/05*	

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		3. Effexor XR Intermittent Explosive Disorder 01/20/06 It is, of course, conceivable that a specific behavior could be related to an underlying psychiatric disorder and also be effected by environmental and/or behavior factors. In those situations, where there is evidence to support that the behaviors have both biological and behavioral determinants, this distinction should be identified, documented, and verified. As with the identification of symptoms that support the psychiatric diagnosis, once this process has been completed, the information can be carried forward in the records and modified as needed in the future. This process might also reveal that there are individuals for whom psychiatric medication is being utilized primarily to suppress behaviors that are derived from and maintained by behavior/environmental factors. In those cases, the IDT should reconsider the appropriateness of continued use of those medications. As noted above, another important aspect of this provision relates to the effectiveness of the psychotropic medication. The behavioral data present in the sample from the prior monitoring review lacked the sufficient information necessary for either the IDT or an external reviewer to determine if the medications that were currently being utilized had been effective to a degree that justified their continued use. A significant contribution to this deficiency was the lack of any baseline data that could be compared to the contemporary data to determine efficacy. This problem was carried over into the current review. With the exception of two individuals (Individual #52 and Individual #101), there was insufficient information to indicate that the existing psychotropic medication had been of therapeutic benefit. The Psychiatry Department added a column to the listing of the psychotropic medications in the Monthly and Quarterly Psychiatric Clinic notes to identify the expected time frame for the therapeutics effects of the medication to be realized. However, the utility of this information was hampered by the lack of adequate behavioral data tracking information. In addition, this information was not commented on in the narrative discussions of the medication nor did it appear to effect clinical decisions related to the continuation of the medication. The Psychiatry Department, working in collaboration with the Psychology Department, should be able to construct data collection and reporting systems that make this type of historical analysis possible. Examples of effective strategies include graphs with phase lines that indicate the time of changes in psychotropic medications, as well as changes in behavioral interventions with the ongoing frequencies of the monitored behaviors. Tabular systems that carry forward the first three months of data following the introduction of the psychotropic medication, and/or a change in dosage can also provide this information, but can be cumbersome to maintain. This issue was discussed during	

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		the current review. One mechanism for beginning to initiate this process would be to identify those individuals for whom it is believed that there has been unequivocal evidence that a particular medication has been effective, and then devise a way to illustrate this positive response. This exercise could produce a template that could then be used throughout the population of individuals receiving psychotropic medication.	
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.	The section of the medical record that contained the Informed Consents related to the use of psychotropic medications was reviewed for the entire sample of 27 individuals, which indicated a completion rate of 100%. The Guardian of the Person signed the consent documentation for eight individuals (30%). The Facility Director signed the Informed Consents for the remaining individuals who did not have a Guardian. This review indicated that signed consent documentation was consistently being obtained for the individuals who resided at the CCSSLC. However, the Risk versus Benefits sections in the records, as discussed with regard to Section J.10, were so minimal and formulaic in nature that it is doubtful the information presented to the Guardian or Facility Director would have been sufficient to provide a truly informed decision. The integrity of the risk versus benefit determination process is inherently linked to the Informed Consent process. The implementation of changes to the sections of the record related to the risk versus benefit consideration in the use of psychotropic medication should make it possible to provide the necessary information to the Guardians, so that they can make an informed decision regarding their approval for an individual's psychotropic medication.	Noncompliance
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.	The prior monitoring report identified deficiencies in the communication of relevant clinical information between the Psychiatrist and the Neurologist, related to individuals who were followed by both disciplines. In response to these observations, the Psychiatry Department implemented a system that was meant to ensure that the Neurologist would review and comment on the most recent Psychiatric Consultation Notes. The notes from any neurological consultations that had occurred since the last psychiatric consultation also would be reviewed and documented during the next Psychiatric Clinic for that individual. The effectiveness of this new policy was assessed using three strategies. First, a spreadsheet including all individuals who were followed in the Psychiatry Clinics and who also had been seen in the Neurology Clinic, since October 2010, was requested. From that list, four individuals were randomly selected and the notes from the Psychiatric Clinic that occurred after the Neurology Consultation were requested. The specific documentation requested was as follows: Individual #285's Psychiatric Consultation, dated 12/15/10; Individual #47's Psychiatric Consultation, dated	Noncompliance

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		10/12/10; Individual #19's Psychiatric Consultation, dated 12/15/10; and Individual #176's Psychiatric Consultation, dated 10/5/10. The documentation from these notes included a specific reference to the relevant clinical information contained in the most recent Neurology Consult. The second method involved requesting the relevant data related to the Psychiatric Clinics observed during the onsite review. The Psychiatric Clinics that were observed on 1/4/11 indicated that the following individuals had been seen in the Neurology Clinic on the dates indicated: Individual #49 on 12/18/10, and Individual #292 on 11/27/10. The corresponding Neurology Note was requested and reviewed to ascertain if the summary contained in the Psychiatric Clinic was accurate, and also to verify that the Neurology Note referenced the individual's psychiatric status and related medications. These points were verified in both documents. The Neurology section of the records for the 27 individuals reviewed in the current sample indicated that the Consulting Neurologist had seen the following 12 individuals within the last year: Individual #136, Individual #281, Individual #308, Individual #18, Individual #305, Individual #58, Individual #202, Individual #333, Individual #19, Individual #327, Individual #49, and Individual #10. The most recent Neurology Notes for nine individuals (75%) contained reference to the psychotropic medications and the most recent Psychiatric Consultation, including: Individual #18, Individual #305, Individual #58, Individual #202, Individual #19, Individual #327, Individual #49, Individual #10, and Individual #281. Reference to the most recent Neurology Consultation was located in the Psychiatric notes for three individuals (25%), including: Individual #327, Individual #10, and Individual #136. However, the Neurology Consultation for these three individuals was so recent that a reference to this Consultation could not have been expected to be present in the record, because they would likely not yet have been reviewed in the January 2011 Monthly Psychiatric Clinic. The dates of these Neurology Consultations were as follows: Individual #58 on 12/18/10, Individual #49 on 12/18/10, and Individual #18 on 12/18/10. At the time of the Monitoring Team's onsite review, the system described above had only been implemented within recent months. Thus, one would not expect to find the full evidence of this process reflected in the random sample. The review of the two more recent sub-samples described above found evidence that the process was effective in facilitating written communication between the Consulting Psychiatrist and Neurologist. The degree to which this methodology can be sustained will be assessed in future	

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		reviews.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The initiative to document the symptoms that support the psychiatric diagnosis in the Psychiatric Clinic Notes should continue.
2. The Psychiatry and Psychology Departments should investigate and address the dual classification of individual behaviors as both targets of the psychotropic medication, and as being described in the Functional Analysis and Positive Behavior Support Plan as being present on a learned basis or as a response to environmental factors. If a specific behavior is listed as both being present on a behavioral basis and also as a target behavior of psychotropic medication, the rationale should be identified and documented.
3. Psychiatry staffing should be increased to the two full-time equivalent positions currently budgeted for CCSSLC. The Facility should continue to advertise and make every effort to fill these psychiatry positions.
4. Strategies should be developed to document the efficacy of individual psychotropic medications.
5. The Risk versus Benefit Analysis/Human Rights approval process should be revised with a view toward assessing the risks and benefits presented by each prescribed medication, and in a manner that more fully articulates the probability of the potential benefits, as well as any potential risks.
6. The linkage between the psychiatric diagnosis and the identified target behavior of the psychotropic medication should be documented. For example, how does the diagnosis of Obsessive-Compulsive Disorder produce a target behavior of aggression?
7. The factors that contribute to the deficiencies in the completion rates of the MOSES and DISCUS side effect ratings should be investigated and addressed.
8. The internal review processes described in the POI should be refined to include quality parameters in addition to completion rates where appropriate.
9. The newly developed process to facilitate communication between the Consulting Psychiatrist and Neurologist and to develop strategies that track the efficacy of this process should continue.
10. The Psychiatric Assessment template being used should be reviewed to ensure it contains all of the components included in Appendix B of the Settlement Agreement.
11. Information should be included in the Comprehensive Psychiatric Assessments that describes the symptoms that support the psychiatric diagnosis, identifies the linkage between the psychiatric diagnosis and behavioral targets of the psychotropic medications, and documents the efficacy of the psychotropic medications.
12. The existing data-collection system should be modified so that it can be utilized to document the efficacy of psychotropic medications in decreasing the frequency and intensity of the behaviors for which they are prescribed.
13. Procedures and individualized programs should be developed and implemented that will decrease the reliance on psychotropic medication used for pre-treatment sedation of individuals for medical and dental procedures.
14. Efforts should continue to monitor and reduce polypharmacy with psychotropic medication. This will require improvements in the systems for identifying and monitoring the symptoms of psychiatric diagnoses, and prescribed medications effects on such symptoms.

The following are offered as additional suggestions to the State and Facility:

1. Consideration should be given to integrating the Treatment Plans, for the use of psychotropic medications, with the Behavioral Support Plan, so that it is clear which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies.

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:** The following activities occurred to assess compliance: ▪ **Review of the Following Documents**: o CCSSLC Psychological and Behavioral Services Policies, including the following documents that were revised on 7/1/10, approved on 7/9/10, and implemented on 8/9/10: 1) Positive Behavior Support Staffing; 2) Psychological Evaluations; 3) Structural and Functional Assessments; 4) Positive Behavior Support Plan; 5) Counseling; 6) Suicide Precaution Guidelines; 7) Competency Based Training for PBSP; 8) Measurement and Analysis of Effectiveness of Positive Behavior Supports; and 9) System to Review Quality; o Summary of Behavioral Services Position Credentials, dated 11/24/10 and 12/20/10; o Behavioral Services Action Plan to "Develop, Recruit and/or Retain BCBA [Board Certified Behavior Analyst] for CCSSLC"; o Email and meeting minutes, dated 11/2/10, related to barriers in taking graduate coursework toward the BCBA; o Signed statement from BCBA consultant ensuring adequate hours for supervision; o Training Documentation of New Psychology Templates – Psychological Assessment, Structural Functional Behavior Assessment (SFBA), Positive Behavior Support Plan (PBSP), Safety Plan for Crisis Intervention (SPCI), dated 12/28/10; o Training Documentation of Completion and Documentation of Psychological and Behavioral Assessments, Plans, and Flowcharts, dated 12/28/10; o Training Documentation of Positive Behavior Support Plan – New Template, dated 10/4/10; o Training Documentation – Crisis Intervention, dated 10/6/10; o Training Documentation – Desensitization Plan Development, dated 9/30/10; o Training Documentation – PSP At-Risk Format, dated 12/13/10 through 12/15/10); o Training Documentation – Basic Functions of Behavior, dated 10/21/10; o Training Documentation – Responding to Behavior, dated 12/2/10; o Training Documentation – Replacement Behaviors, dated 11/18/10: o Training Documentation – Prevention of Behavior, dated 11/4/10; o CCSSLC Record Request for Section 1 (#12); o Summary Template indicating, behavioral services staff by position/title, degree, completed coursework, updated 10/20/10; o Online advertisement for Psychologist III/Chief Psychologist from the Health and Human Services Jobs Center, undated; o Behavioral Services Employee Information (diploma, etc.), undated; o CCSSLC Habilitation Therapies: Speech Department Communication Dictionaries – Procedures for Collaboration between Psychology and Speech, dated 11/1/10; o CCSSLC Behavioral Data Collection Process, undated; o Competency Check for Behavior Support Plan – blank rubric, undated; o Behavioral Data Collection Process – Competency Exam, undated;

	o Example of a Monthly Behavior Data Sheet; o Behavior Services Committee (BSC) Spreadsheet – CCSSLC: Psychological Evaluation, dated 1/3/11; o BSC Spreadsheet – CCSSLC: Individuals with SFBAs, dated, 1/6/11; o BSC Spreadsheet – CCSSLC: Individuals with PBSPs, dated, 1/6/11; o BSC Spreadsheet – CCSSLC: Individuals with Desensitization Plans, dated 1/3/11; o BSC Spreadsheet – CCSSLC: Individuals with SPCIs, dated 1/7/11; o Behavior Support Committee Meeting Minutes, dated June 2010 through December 2010; o Skill Acquisition Plans and PSP Monthly Reviews, as available, for: Individual #145, Individual #255, Individual #47, Individual #244, Individual #311, Individual #251, Individual #275, Individual #246, Individual #268, Individual #70, Individual #109, Individual #305, Individual #307, Individual #118, Individual #7, Individual #243, Individual #300, Individual #333, Individual #92, Individual #42, Individual #10, Individual #348, and Individual #32; o Psychological Assessments and Inventory for Client and Agency Planning (ICAP) evaluations, as available, for: Individual #145, Individual #255, Individual #47, Individual #243, Individual #311, Individual #251, Individual #275, Individual #246, Individual #268, Individual #70, Individual #109, Individual #305, Individual #307, Individual #118, Individual #7, Individual #243, Individual #300, Individual #333, Individual #92, Individual #42, Individual #10, and Individual #32; o Summary Listing of Individuals Receiving Counseling, November 2010; o CCSSLC Behavioral Services - Counseling Progress Note, undated; o CCSSLC Behavioral Services – Psychotherapy Referral Process, dated 8/20/09; o CCSSLC Behavioral Services – Psychotherapy Referral Form, dated 8/20/09; o CCSSLC Behavioral Services – Counseling Treatment Plan, undated; o Listing of Measureable Objectives for 11 Individuals from CCSSLC's Contracted Counselor, dated 12/20/10; o Email describing referral process for supplemental psychological services, dated 12/18/10; o Counseling/psychotherapy treatment plans/goals for: Individual #26, Individual #230, Individual #275, Individual #246, Individual #140, Individual #6, Individual #51, Individual #7, Individual #94, Individual #357, and Individual #325; o CCSSLC Position Description – Autism Specialist, undated; o Onsite record reviews of: Individual #300, Individual #51, Individual #348, Individual #251, Individual #307, Individual #77, Individual #42, Individual #311, Individual #243, Individual 246, Individual #47, and Individual #255; o PSP addendums as provided related to PST meetings discussing barriers to participating in off-site day or vocational programming for Individual #153, Individual #83, Individual #234, Individual #311, Individual #36, Individual #270, Individual #6, Individual #122, Individual #179, Individual #196, and Individual #323.and o PBSPs, SPCIs, Consent for Treatment, and Training Documentation (referred to as "ITTPs") for these documents, and Consent for Treatment forms, as available, for: Individual #145,

	Individual #251, Individual #255, Individual #311, Individual #275, Individual #109, Individual #307, Individual #7, Individual #92, Individual #300, Individual #243, Individual #42, Individual #246, Individual #118, Individual #47, and Individual #268. o Section K completed Monitoring Tools, dated 11/5/10, 11/6/10, 11/29/10, 12/7/10, 12/8/10, and 12/14/10 (two reports on this date); ▪ **Interviews and Meetings with**: o Dr. Robert Cramer, Clinical Psychologist, on 1/3/11; o Iva Benson, Facility Director, and Mark Cazalas, Assistant Director of Programs, on 1/4/11; o Bruce Boswell, Director of Day Programs/Active Treatment and Interim Acting Director of Behavioral Services; Dr. Robert Cramer, Clinical Psychologist; and Everett Bush, Psychologist, on 1/4/10; o Bruce Boswell, Director of Day Programs and Active Treatment and Interim Director of Behavioral Services, and Rachel Rodriquez, QMRP Coordinator, on 1/5/11; and, o Dr. Robert Cramer, Clinical Psychologist, and Everett Bush, Psychologist, on 1/6/11; and o Bruce Boswell, Director of Day Programs and Active Treatment and Interim Director of Behavioral Services, on 1/6/11. ▪ **Observations Conducted**: o Observation and discussion with staff members at the Behavioral Support Committee Meeting, on 1/4/11; o Observation and discussion with staff members at the Skill Acquisition Review Committee meeting, on 1/5/11; o Observation of Personal Support Team (PST) members at the Personal Support Plan (PSP) Meeting for Individual #338, on 1/6/11; o Onsite direct observation, including interaction with direct support professionals, and other professionals including residence coordinators, psychologists, psychology assistants, home team leaders and assistants, active treatment supervisors, active treatment specialists, community integration specialists, vocational coordinators, rehabilitation therapy technicians, and/or QMRPs were conducted throughout the morning, day, and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Apartment 511 (Pompano), on 1/3/11 and 1/6/11; ▪ Apartment 517 (Angelfish), on 1/3/11 and 1/6/11; ▪ Apartment 514 (Dolphin), on 1/4/11 and 1/6/11; ▪ Apartment 518 (Porpoise), on 1/4/11 and 1/6/11; ▪ Annex and Canteen, on 1/5/11; ▪ Habilitation Therapies Building, on 1/5/11; ▪ Vocational Building, on 1/5/11; ▪ Adult Life Skills Building (512), on 1/5/11; ▪ Apartment 510 (Sailfish), on 1/5/11; ▪ Apartment 522B (Kingfish 2) on 1/5/11; ▪ Apartment 522A (Kingfish 1) on 1/5/11;

	▪ Apartment 516 (Sanddollar), on 1/6/11; ▪ Apartment 515 (Seahorse), on 1/6/11; ▪ Apartment 522C (Kingfish 3), on 1/6/11; and ▪ Apartment 522D (Kingfish 4), on 1/6/11.
	Facility Self-Assessment: The Facility had developed a Plan of Improvement (POI) with regard to Section K of the Settlement Agreement. The POI contained outcomes, action steps, required evidence, Facility target dates, completion status, a determination of non-compliance (N) or substantial compliance (S), and additional comments. The POI included four action plans and the associated action steps, evidence, start/target dates, and completion status. It appeared that the Facility completed four out of five action plans identified within the POI. These activities are discussed as appropriate throughout the remainder of this section. The Facility developed a self-assessment tool based on the Monitoring Teams' Section K rubric. Verbal reports indicated that staff members (including psychologists and QI/QA) had been completing these chart reviews regularly. Documentation included examples of seven self-assessment tools (completed by seven different psychologists) that were conducted in November and December 2010 across different residential programs. At the time of the review, meetings had been planned with behavioral services staff to review completed assessments and examine issues related to the use of this tool (e.g., utilized procedures, item comprehension, agreement of scores, etc.) in an effort to promote better integrity of implementation and agreement, but had not yet taken place. Currently, there was no summary data available for review. This process will need to continue to be developed in order for self-assessment activities to be complete. According to the POI, CCSSLC indicated that it was in substantial compliance with Sections K.2 and noncompliance with all of the remaining sections. These findings were consistent with the Monitoring Team's review with one exception. Based on the Monitoring Team's review, the Facility was Not Rated on Section K.2. More specifically, due to recent changes within the position of Chief Psychologist, the Monitoring Team did not have sufficient information to rate Section K.2 until a newly appointed Chief of Psychology had been in place for a sufficient period of time to allow a fair and adequate examination of the person's ability to maintain a consistent level of psychological care throughout the Facility.
	Summary of Monitor's Assessment: Evidence of progress was observed in many areas of Psychological Care and Services. However, as expected, many areas still required additional time and effort to adequately address components of the SA. Progress was observed in the area of staff development since the last review. Five psychologists completed graduate classes this past Fall and advanced toward completing coursework prerequisites for the BCBA exam. Currently, five (33%) out of 15 eligible psychologists had completed one or more courses toward BCBA certification. Necessary supervision for application to take the exam, however, had not yet started for any of the psychologists.

	Peer review continued to occur through the Behavior Support Committee (BSC) as well as though the contribution of the contracted BCBA. Concern was noted regarding the consistent attendance of the full membership, as well as with the regularity of scheduled meetings. At the time of the review, supplemental external peer review continued to be pursued. Graphic display of data had continued to improve since the previous review, although continued refinement of graphing conventions was necessary. Concern was again noted with regard to the consistency and reliability of data collection. Findings regarding the adequacy of data collection across programs and settings would best be described as mixed. At the time of the current review, inter-observer agreement (IOA) data collection had not yet been initiated. Progress had been made in the area of psychological evaluation. A new psychological evaluation update format was introduced and was being utilized. In addition, a significant number of Structural and Functional Behavior Assessments (SFBA) were completed since the previous review. As more and more psychologists become competent in conducting these assessments, the likelihood of developing more effective assessment-linked interventions increases. For now, many psychologists struggled with the learning curve associated with completing these complex assessments accurately. Limited progress was noted in the provision of counseling services. Although additional counseling supports had been identified, the nature of these services needed to be outlined within treatment plans, utilizing evidenced-based practices and regular review. Progress was observed in the area of PBSPs since the previous review. A new PBSP format had been implemented and a new Behavior Support Committee (BSC) coversheet and spreadsheet were developed to track dates associated with psychological assessments and programming. The new PBSP format appeared likely to improve the quality of behavioral programming and promote improved treatment integrity. Areas for improvement were similar to those identified in the previous reports. Although systems developed to examine the treatment integrity of PBSPs has been implemented, summary data was not currently available for review. Similarly, data to demonstrate adequate competency-based training was also unavailable for review.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who	At the previous Monitoring Team visit in July 2010, it was established that progress had been made in developing and implementing a policy targeting the recruitment and/or training of BCBA-level professionals. This included a new policy, "Psychological and Behavioral Services Positive Behavior Support Staffing," that had been written, approved and implemented. It set forth a process to develop, recruit, and/or retain BCBA and Board Certified Assistant Behavior Analyst (BCABA) level behavior analysts. This policy involved a three-tiered approach, and CCSSLC had started to implement the first of these three steps by contracting with a BCBA consultant to provide supervision for Psychology	Noncompliance

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	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.	staff undergoing the certification process, as well as peer review and case consultation. According to verbal reports, Behavior Support Committee (BSC) meeting minutes, and direct observation, the BCBA contractor had been available for case consultation and peer review, including weekly review of behavioral programming at the Behavior Support Committee, as well as recent participation with the Skill Acquisition Plan Review Committee. Verbal reports at the time of the most recent Monitoring visit indicated that the involvement of the BCBA contractor would increase significantly as she had committed to participating, in addition to her consistent weekly attendance at BSC meetings, a majority (three or four) of Skill Acquisition Plan Review Committee meetings per month. Progress had been made by some behavioral services staff members in obtaining the graduate coursework necessary to apply for the BCBA exam. According to documentation (i.e., summary template provided in response to the initial document request), five staff members completed coursework this past Fall. Based on previous verbal reports from staff, it appeared that a few staff dropped out of coursework this past Fall. Overall, five, two and one staff members had completed course #1, #2, and #3, respectively, at the University of North Texas (UNT). In total, five (33%) out of 15 eligible psychologists had completed one or more courses toward BCBA certification. Of note, information presented here, based on initially provided documentation, was inconsistent with data provided in the Plan of Improvement. The Monitoring Team has made the assumption that the POI, dated 9/27/10, included data that changed due to staffing changes by the time of the Monitoring visit in January 2010. According to verbal reports, in addition to providing tuition support (that was in place during the last visit), the State had recently announced the availability of educational leave (i.e., up to 4 hours a week) for staff enrolled in coursework. It is hoped that these incentives and supports will encourage more of the current staff to enroll in courses. Documentation provided demonstrated continued efforts at meeting with Behavioral Services staff to identify barriers to and necessary supports for completing coursework. Unfortunately, at the time of the Monitoring Team's on-site review, no formal supervision (necessary for application for BCBA certification) has occurred since the last visit. Verbal reports indicated that formal supervision would be provided for the Clinical Psychologist starting in January 2011. If this supervision appeared effective and mutually acceptable, the plan would include increasing the available supervision to other CCSSLC behavioral services staff members who were enrolled in coursework. A few staffing changes within Behavioral Services had occurred since the Monitoring Team's last visit in July. This included the departure of the previous Clinical Psychologist,	

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		as well as the change in position of the former Chief Psychologist into the recently vacated position of Clinical Psychologist. This is discussed in more detail with regard to Section K.2. At the time of the most recent review, Bruce Boswell was the Acting Interim Director of Behavioral Services. According to discussion with the Facility Director, and Assistant Director of Programs, this interim position was temporary as CCSSLC searched for and hired a Chief Psychologist. Documentation provided indicated that CCSSLC had started advertising for this open position. Although the advertised position required licensure as a Psychologist with the State of Texas (or a reciprocity state), it did not specifically reflect a desire for or requirement of a BCBA. In addition, a new psychologist was hired just prior to the recent Monitoring visit. This new employee has a Master's degree from Texas A and M University-Corpus Christi, and had taken an Associate Psychologist V position. Overall, the current CCSSLC policy, Psychological Care and Services – Positive Behavior Support Staffing, remained in place. This policy appeared to contain procedures to recruit and/or train professionals with competencies in Applied Behavior Analysis (ABA), and to audit credentials. It was unclear how CCSSLC would respond to current employees who were not enrolled in coursework and, subsequently, not in compliance with the current policy. It appeared that many of the barriers initially identified with registering for the coursework (e.g., the cost, time, etc.) had been removed. This provision item was rated as being in noncompliance, because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	A significant change regarding the position of Director of Behavioral Services had occurred since the last review. More specifically, the previous Director of Behavioral Services and Chief Psychologist no longer held this position. Because this change was unanticipated and occurred so closely to the current review in January, it did not allow the sufficient time to establish whether or not the Interim Acting Director had established and maintained a consistent set of psychological practices throughout the Facility. As a result, the Monitoring Team has not rated the Facility's compliance with this provision. As recruitment efforts were underway for a new Director of Behavioral Services and Chief Psychologist, it is likely that the newly appointed Chief of Psychology will have been in place for a sufficient period of time to allow the Monitoring Team during the next review to assess the person's ability to maintain a consistent level of psychological care throughout the Facility.	Not Rated

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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.	Limited progress had been noted in the area of peer review within Psychological and Behavioral Services. A new policy addressing peer review, entitled Psychological Care and Services – System to Review Quality was approved and implemented on 7/9/10 and 8/9/10, respectively. This policy appeared consistent with the previous policy ("Psychological and Behavioral Services System to Review Quality") that was developed, but not yet implemented at the time of the last review. This policy addressed the review of Positive Behavior Support Plans and Psychological Assessments, including Structural and Functional Behavior Assessments, and outlined the composition and roles of internal as well as external reviews. Currently, the internal review was established through weekly Behavior Support Committee peer review. It was unclear why Safety Plans for Crisis Intervention were not part of this policy as they were reviewed regularly at the BSC as well. BSC meeting minutes were reviewed for the period of 6/1/10 through 12/28/10 in an effort to examine the adherence to expected schedule (i.e., weekly reviews) and diversity of membership as outlined in the policy. During this time period, it appeared that the BSC met approximately 19 times. This is a generous estimate given that a few of the meeting minutes did not include any indication of who attended, other than the Director of Behavioral Services (i.e., 6/8/10 and 8/3/10), and a single document listed two different meeting dates (6/22/10 and 6/29/10). As a result, it was unclear if two different meetings were held (represented by a combined meeting minutes), or if one meeting was held and included the scheduled agendas from both meetings (to make up for several cancelled dates). On some meeting minutes, however, it was clear that the meeting had been cancelled (e.g., 6/1/10, 6/15/10, 7/27/10, 8/10/10, 8/24/10, 9/7/10, and 11/16/10). Consequently, it appeared that the BSC met for 61% of the projected 31 potential scheduled meetings during this time period. Of note, five weeks of meeting minutes were missing from provided documentation. The current CCSSLC policy endorsed and recommended a diverse membership of the BSC. In an effort to examine the diversity of membership, BSC meeting minutes were reviewed during the same period as listed above. In general, the consistent diversity of meeting attendees was less than anticipated. Behavior services staff, including psychologists and psychological assistants, obviously made up the largest percentage of participants, followed by psychiatric assistants and the BCBA consultant who were in attendance approximately 47% of the time. Representatives from nursing, habilitation therapies, or administration were typically each in attendance less than 26% of the time. Several important key players, for example, those who supervise the implementation of behavioral programming including psychology assistants and residence coordinators, were not referenced in the policy. It is important to involve those who have direct administrative supervisory authority of the plans, as well as anyone who was directly	Noncompliance

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		involved in the plans' design and/or training. As recently noted on the POI, plans were only reviewed at BSC if certain individuals (i.e., supervising psychologist, psychology assistant, and unit director) were in attendance. Of these individuals listed, only the author was referenced in the current policy. The policy should include these additional staff members. Similar to the previous onsite review, direct observation of a BSC meeting by a member of the Monitoring Team reflected good attendance by behavioral services staff as well as other professionals, active participation of team members, and data-based review and decision-making. As previously reported, it continued to appear that a substantial number of documents (e.g., Psychological Evaluations, SFBAs, PBSPs, and SPCIs) in addition to ongoing Psychology Department business (e.g., review of delinquent reports) were reviewed at each weekly meeting. This had the potential to limit the committee's ability to thoroughly review each presented assessment and/or plan. As previously recommended, a process should be established (e.g., a hierarchy based on restrictiveness, etc.) that ensures sufficient time for adequate review, especially of the most intensive or challenging of cases. This process appeared of even greater need given the frequencies in which meetings were cancelled. As identified during the previous review, current CCSSLC policy did not appear to conspicuously state the annual requirement for BSC review of Psychological Assessments, SFBA, PBSPs, and/or SPCIs. Review of information displayed on the BSC Spreadsheet indicated that BSC approval dates for Psychological Evaluations, Structural and Functional Behavioral Assessments, Positive Behavior Support Plans, and Safety Plans for Crisis Intervention were tracked over time. Evaluation and/or BSC review dates recorded on this tracking tool suggested that a certain percentage of annual Psychological Evaluations (36%), PBSPs (19%), and SPCIs (38%) had lapsed. Data on the recently completed SFBAs indicated that, as of 1/6/11, 159 had been completed and 57 remained to be completed. According to the POI, the spreadsheet had just begun to be populated on 12/1/10, and because this system was new, it was likely that there may be some errors. Indeed, a number of individuals did not have any dates recorded in some cells within tracking spreadsheets. For example, 47 individuals (14%) did not have evaluation dates recorded in the Psychological Evaluation spreadsheet. As a result, it was very difficult to determine if data was simply missing or if an evaluation was never completed. As observed during the previous review, procedures regarding external peer review had	

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		been developed and included within CCSSLC policy. The BCBA consultant had continued to provide peer review through her on-site BSC meeting attendance. As indicated above, she has participated in approximately 47% of BSC meetings since June 2010. Verbal reports also indicated that she had completed additional case reviews. Additional supplemental external peer review through the use of other BCBA-level professionals, for example, continued to be pursued.	
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.	At the last Monitoring visit in July 2010, it was observed that significant progress had been made since the initial January 2010 baseline visit in the area of data collection regarding PBSPs, SPCIs, and PSP Monthly Reviews of Behavioral Services. At the time of the most recent review, it appeared that progress had continued to take place. Even though progress continued, concerns remained about the adequacy of the data. In an attempt to examine the nature of data collection, a sample of 15 PBSPs were selected and closely reviewed. This sample reflected nine percent of the total PBSPs currently in place. Of this sample, 15 (100%) prescribed data collection of one or more target behaviors and one or more replacement behaviors. As presented below with regard to Section K.9 of the SA, however, there were concerns with how behaviors were operationally defined. In addition, of this sample, 15 (100%) had data displayed either in a table, a graph, or both, within the PBSP and PSP Monthly Reviews of Behavioral Services. This data included target behaviors and replacement behaviors, as well as data on restraints and medications, as appropriate. For two PBSPs however, (i.e., Individual #109 and Individual #118), data was only available in table format within the PBSPs. Indeed, this limitation (lack of graphic displays) for these two individuals was surprising, given that graphs were included within monthly PSP reviews for each. Of this sample, 13 (87%) individuals had SFBAs completed within the last 12 months. Of these 13 SFBAs, 13 (100%) contained data displayed either in table or graphic form. Review of psychological assessments evidenced a mixed finding related to data display. More specifically, eight (53%) psychological assessments contained behavioral data displayed either in table or graphs. In addition, of the individuals within this sample with Safety Plans for Crisis Intervention (SPCIs), four (100%) prescribed the collection of restraint data, which was tracked and monitored on PSP Monthly Reviews of Behavioral Services. Information on restraints was presented as frequency data. Overall, data display using graphs had continued to improve. Documentation reviewed indicated that, for all individuals sampled, monthly review of behavioral data included graphic display of both target and replacement behaviors. The quality of the graphic display as discussed with regard to Section K.10 of the Settlement Agreement, however, continued to be problematic.	Noncompliance

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		Direct observation, including several on-site record reviews, also continued to evidence inconsistency in data collection. That is, reviewed behavioral and skill acquisition data was not consistently collected as prescribed. With regard to skill acquisition programs, data was missing from oral hygiene skill plans from January for Individual #92, Individual #255, Individual #246, and Individual #47. This is discussed in further detail with regard to Section S.3 of the Settlement Agreement. With regard to PBSPs, some of the data sheets reviewed evidenced inadequate data collection, for example: 1) 31% of intervals missing data from 1/1/ 11 to 1/3/11 for Individual #251; 2) 60% of intervals missing data from 1/1/11 to 1/5/11; 3) 31% of intervals missing data from 1/1/11 to 1/5/11; 4) 93% of intervals missing data from 1/1/11 to 1/5/11; 5) 70% of intervals missing data from 1/1/11 to 1/6/11; and, 6) 33% of intervals missing data from 1/1/11 to 1/5/11. More importantly, PBSP data ("00") was already recorded on the 6:00 a.m. to 2:00 p.m. shift (on 1/6/11) for Individual #77 even though the shift had not been completed. Some of the documentation reviewed during the brief on-site visits, however, evidenced adequate data collection, for example: 1) 100% of the data for a skill acquisition program was collected for Individual #208; 2) 100% of the data for a skill acquisition program was collected for Individual #300; 3) 100% of the data for a skill acquisition program targeting a replacement behavior was collected for Individual #51; 4) 80% of the data for a skill acquisition program was collected for Individual #311; 5) 100% of the PBSP data for Individual #348 was collected; and, 6) 94% of the PBSP data for Individual #255 was collected. Lastly, improvement in the current data collection system was observed, because data books were readily available for review during onsite visits. However, it was still difficult to estimate how well data systems had been individualized. It was obvious that data sheets contained individualized legends to utilize when recording data. However, it was unclear the extent that different data collection methodologies (e.g., partial interval recording, duration recording, etc.) had been individualized to observed responding. Currently, according to provided documentation, a standardized behavioral data collection process was in place, including the availability of a data sheet rubric. In addition, psychologists were encouraged to individualize this sheet. This process was outlined in a policy entitled Behavioral Services – Behavior Data Collection Procedures. However, it was unclear if this policy was recently revised and why it was not included with other policies under Psychological Care and Services. Verbal reports from the Clinical Psychologist indicated that efforts had been made to improve the operational definitions of target and replacement behaviors, ensure that data recording occurred more immediately, and that data sheets were individualized, when appropriate. At the time of the review, data reliability was not being assessed. This finding is similar	

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		to the finding at the previous review in July 2010. This is discussed further below with regard to Section K.10 of the Settlement Agreement. Verbal reports indicated that psychological and behavioral services staff were still working to determine the most effective and efficient methods to collect inter-observer agreement. Data collection systems, including the degree of individualization as well as the estimation of reliability, will be a primary focus of the next Monitoring visit.	
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.	Progress was observed in the area of psychological assessment, as well as in the completion of structural and functional behavioral assessments, including the use of a newly revised format. As presented below with regard to Section K.6, of the 22 psychological assessments sampled, 22 (100%) contained the findings from previously completed standardized tests of intelligence. Currently, only four (18%) individuals within this sample had standardized tests of IQ and Adaptive Behavior completed within the last five years (i.e., Individual #10, Individual #92, Individual #333, and Individual #300). The majority of individuals (64%) participated in these tests over 10 years ago. In addition, 22 (100%) of the sampled individuals had an ICAP evaluation completed within the last three years. As observed during the previous Monitoring reviews, in addition to the above assessments, screening for psychopathology, emotional and behavioral issues continued to be completed either through the psychiatric clinic's completion of a psychiatric assessment, or through the utilization of the Reiss Screen for Maladaptive Behavior to screen for the need of a psychiatric assessment. The Reiss screenings continued to be utilized on an annual basis to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss screening process is discussed above with regard to Section J.7 of the SA. Approximately 15 (68%) of the psychological assessment reviewed were completed adhering to a more recently revised standardized format. This new format was much more comprehensive than previously utilized rubrics and, in addition to previous sections, contained information obtained through clinical interview and observation, and on mental status, developmental history, psychiatric functioning, and provided a summary of assessment findings. An additional improvement in this new format compared to previous formats was the elimination of sections related to functional behavioral assessment. This information was more suited for the SFBA report. Since the initial baseline review, a significant improvement in the area of assessment had been the increasing number of SFBAs that had been completed. As was reported within the previous Monitoring report, 28 SFBAs had been completed since January 2010. At the time of the most recent review, according to the BSC Spreadsheet, there had been 159	Noncompliance

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		SFBAs completed. However, the format of SBFAs had changed over the past year and the most recent format was just implemented. To examine the content of current SFBAs, 10 individuals with SFBAs completed within the last 6 months were selected (from the original sample). Two of the individuals selected (Individual #145 and Individual #243), had SFBAs that were written in the new format. When compared to the rest of the sample, these two plans were the best. Based on this limited review, it appeared that the new format was an improvement. All of the SFBAs reviewed utilized a standard explanation for why the SFBA was developed. This included a statement explaining its purpose to report assessment findings, examine previous patterns of responding, determine the nature and function of behavior, and inform intervention. This also usually included a statement reflecting the completion of this assessment in preparation for the upcoming annual PSP meeting. None of the reviewed SFBAs indicated that they were completed or revised because the individual did not meet treatment goals or was experiencing significant changes in functioning. Eventually, some SFBAs are likely to be revised or updated due to changes in functioning not primarily in preparation for the PSP. At those times, the rationale should highlight the rationale (e.g., significant changes in frequency or intensity of target behaviors) for why the assessment is being revised. At times, preferences were identified within SFBAs, but recommendations on how to use them as potential reinforcers were lacking or description regarding the recommended provision of reinforcement was so nonspecific that it was unhelpful. Identified preferences or reinforcers should be conspicuously integrated within intervention strategies. The following are examples of concerns noted: ▪ The SFBA for Individual #145 stated that she prefers her family, WalMart, campus outings, shoes, helping with small chores, watching videos, and home visits. However, suggestions or comments regarding how to utilize these as reinforcers were not provided. In addition, these items were not conspicuously listed as potential reinforcers in her PBSP. ▪ The recommended reinforcement procedure for Individual #333 stated "… preferred object or activity of choice." The lack of identified reinforcers did not facilitate the development of effective intervention strategies. A disconnect between the identified function(s) on the SFBA and the identified functionally equivalent replacement behaviors continued to be evidenced throughout the review. For example: ▪ The SFBA for Individual #145 clearly identified access to tangibles and social reinforcement as primary functions for disruption. However, the PBSP stated that her behavioral objective was to "… learn to communicate her emotions using her communication board" and "identify her feelings." It was unclear how	

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		emotion identification provided access to desired tangibles or social reinforcement. ▪ The SFBA for Individual #243 identified escape and attention as the primary and secondary functions of his self-injury. However, the replacement behaviors of "participation in his scheduled activity" and "… stating the benefits of asking for help" might not directly teach replacement skills that will allow him to more appropriately escape situations or obtain attention. The replacement behavior of "asking for help," "asking for a break," or "asking to change his schedule" might promote more opportunities to prompt and reinforce a specific response that ultimately might serve the same function. ▪ The SFBA for Individual #109 described three replacement behaviors that all targeted the identification of alternative strategies and not necessarily the use of those strategies. In addition, it was not entirely clear how one or more of the replacement behaviors addressed the primary function identified for aggression. As described in earlier reports, careful consideration of the identified underlying functions of behavior should occur, perhaps evidenced by a summary of all the indirect and direct evidence, and specific function-based interventions should be described and/or recommended. This recommendation appeared to be outlined within the new SFBA format. The reviewed SFBAs continued to demonstrate the ongoing challenge of adequately identifying and defining replacement behaviors. For example: ▪ The following is the replacement behavior for Individual #145: "teach (her) to use her communication board to resolve issues and explain what she wants or needs." This appeared to be a measure of staff's ability to teach her these skills. Perhaps a better definition would have included overt responses that involved "… her independently pointing toward words or pictures on her communication board." ▪ In some cases, the replacement behaviors were not specifically defined, but rather just globally described. For example, with Individual # 255, the replacement behavior included "… identify at least 3 important reasons to participate in daily life responsibilities." It might be more effective to specifically define, prompt, and reinforce a number of correct responses. ▪ In the SFBA for Individual #300, the replacement behavior recommended for aggression was described as "… increasing her ability to exhibit alternative to aggression." Again, "alternative(s)" to aggression should be specifically defined. It might be helpful to encourage behavioral services staff to place less emphasis on the terms "replacement behavior" or "Skill Acquisition Objective" (SAO), as these were typically the terms utilized throughout all the documentation, and more emphasis on the	

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		actual desired responses. The use of these generalized terms appeared to overshadow the necessity of operationally defining specific responses with examples. Indeed, it is very challenging at times to identify the specific replacement behavior in documentation reviewed. This is likely because the replacement behavior was not specifically identified, labeled, or defined. This phenomenon did not happen with target behaviors. That is, most documentation referred to "aggression," "property destruction," etc., and not "target behaviors." The same level of specificity is required for replacement behaviors. Many of the reviewed SBFAs only included indirect assessment methods, usually the Functional Analysis Screening Tool (FAST) or Motivation Assessment Scale (MAS). Only a few assessments, however, actually documented the completion of adequate direct observations and included related data. In addition, some of the reports appeared to complete or summarize obtained data inadequately. Lastly, for some reports, it would have been better to summarize information found in observation notes. For example: ▪ In the Observation Notes section of Individual #255's SFBA, the author repeated data in narrative format that was already displayed in a previous table. This type of redundancy should be avoided. Perhaps using the observation notes section to describe more qualitative aspects of the target behaviors (i.e., observed antecedents, consequences, or aspects of the behaviors topography or intensity). ▪ As noted above, direct observation and/or observation notes section of the SFBA should contain a summary of the potential contingencies related to target behavior, not necessarily a running script of what was observed (e.g., SFBA for Individual #145). If no target behaviors were observed, a potential explanation based on current events might be helpful. In addition, if other forms of descriptive data were collected [e.g., Antecedent-Behavior-Consequence (ABC) data], the SFBA could summarize these episodes and draw conclusions related to the underlying functions (identified hypotheses). ▪ The observation notes for Individual #243 detailed useful information regarding potential antecedents to target behavior. However, it also contained a lot of redundant information that was previously displayed in the graph. The use of direct observation and perhaps other forms of descriptive data collection (ABC data collection) should be clarified, as well as when and how to summarize other forms of obtained data (observation notes, etc.). For example, in some cases, direct observation was simply not completed (e.g., Individual #255, Individual #333, Individual #246, and Individual #348). In addition, in some cases, staff interviews were not summarized (e.g., Individual #255, Individual #300, Individual #333, Individual #251, and Individual #348). Special attention should be given to situations where direct observation is conducted, but target behaviors are not observed. When presented with this dilemma, psychologists might want to summarize potential reasons why the	

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		behavior did not occur, which can be just as informative. This situation often reflects cases where target behaviors are intense but infrequent, thereby making direct observation by psychologists challenging. This might be a case where supplemental data collections methods are desired. Continued challenges in adequately identifying and describing setting events, antecedents, and consequences were observed. It was observed during the previous Monitoring visit that SBFAs authors were struggling with understating these concepts and, subsequently, impairing their ability to potentially understand the contingencies underlying behavior, but also to develop effective behavior programming, including staff training. For example: ▪ The author of the SFBA for Individual #255 mistakenly described setting events as only settings where the behavior was likely to occur. In addition, the consequences described within this section were the therapeutic strategies prescribed within the PBSP. ▪ The SFBA for Individual #10 stated under setting events that: "there is no specific setting in which (his) aggression occurs." This reflected a limited understanding of the concept of setting events. In addition, the consequences described were the therapeutic strategies prescribed within the PBSP, not necessarily the consequences that maintain behavior. ▪ The consequences of SIB as identified for Individual #243 included "scarring," and "discomfort." Indeed, these are consequences of SIB. However, in an SFBA, consequences should be viewed through a "functional lens" and, in this case, described in a way that highlighted potential relationships with underlying functions (escape and attention as identified here). ▪ At times, it would be more helpful if the SFBAs contained more objective descriptions of potential events or states that are likely to increase the demonstration of target behaviors. For example, one setting event described for individual #300 included: "… when she is psychosocially unstable." This is not entirely helpful in identifying situations that might increase the likely target of behaviors. ▪ Antecedents described in the SFBA for Individual #333 did not appear to be related to the target behavior. In fact, it described an antecedent condition related to becoming reclusive. However, the identified consequences of obtaining attention or avoiding an activity were consistent with assessment findings. ▪ A majority of setting events identified in the SFBA for Individual #251 appeared to be better classified as antecedents and the description of the potential antecedents (i.e., "Episodes generally occur when she gets her needs met") was ambiguous.	

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		Additional training should be provided on these concepts, especially the concept of setting events, across all behavioral services staff. In addition, psychologists might require additional direction in resolving situations were assessments might not provide clear findings. In these cases, additional assessments might need to be completed. ▪ When findings from rating scales are inconsistent, additional indirect and/or direct assessments should be completed. For example, the SFBA for Individual #10 indicated that opposing findings from MAS rating scales "did not contribute to this Structural Functional Behavior Assessment." Prior to discarding or invalidating the results, it might have been helpful to more closely examine the difference (e.g., maybe there were different controlling variables across shifts) or supplement the MAS with other assessments, like direct observation or structured interviews. Often, the link between findings of the SFBA and the recommended interventions (for inclusion in PBSPs) were not clearly indicated or obvious. This is more fully discussed in Section K.8 of the SA. For example: ▪ The SFBA for Individual #300 identified escape and access to tangibles as the functions underling her aggressive behavior. However, these findings were not summarized and did not appear to be central to identified recommendations (giving her reassurance and choices), and the identified replacement (i.e., "… alternatives to aggression") lacked the specificity to inform treatment. None of the reviewed SFBAs specifically identified behavioral indices of underlying psychopathology. Although all of the individuals SFBAs identified psychiatric diagnoses and, in almost all cases, listed current psychotropic medications, none of the plans specifically objectively described behavioral correlates. The SFBA for Individual #145 contained a section in which the history of her illness was described and challenging behaviors were described. However, specific behaviors used to monitor psychopathology were not clearly stated. Lastly, some of the reviewed SBFAs contained a level of specificity with regard to the content provided that was unnecessary and counterproductive. Expectations should be established to clearly identify the information that is required, the level of detail that would be helpful, and encouraging summarization and integration of information, when possible. ▪ The SFBA for Individual #348 contained six pages of health information that, in its current state, did not appear helpful. This information should be summarized and findings should be integrated within the broader assessment as well as inform intervention recommendations. ▪ The SFBA for Individual #109 contained over five pages of observation notes, that, in its current state, did not appear helpful. This information should be	

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		summarized and findings should be integrated within the broader assessment as well as inform intervention recommendations. ▪ The Personal Attributes and Interests section of the SFBA for Individual #300 contained very detailed information related to intelligence and adaptive functioning that was redundant as it would have been more appropriately described in the psychological assessment. This information could easily have been summarized and related to how her functioning level impacted her current skills and behavior. In general, as the newly revised SFBA format, dated 12/15/10, becomes more commonly used, it is likely to improve the assessment process and lead to a stronger link between assessment and intervention.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The current CCSSLC Psychological Care and Services – Psychological Evaluations policy indicated that each individual residing at CCSSLC must have a current psychological evaluation. This expectation, that a psychological assessment would be completed, updated and/or reviewed at least annually for each individual served, had not changed since the previous Monitoring visit. This expectation also had included reviewing summary data from the Inventory for Client and Agency Planning (ICAP) evaluation on an annual basis, with the requirement of conducting a re-evaluation using the ICAP at least once every three years or sooner if significant events appeared to impact adaptive functioning. To determine whether or not psychological assessments were based on current, accurate, and complete clinical and behavioral data, documentation related to 22 sampled individuals was examined. As presented below with regard to Section K.7 of the Settlement Agreement, of the 22 sampled psychological assessments reviewed, 19 (86%) were updated within the last 12 months. In addition, 22 (100%) of the sampled individuals had an ICAP evaluation completed within the last three years. It appeared that for some individuals, however, the ICAP score listed in the psychological evaluation was either incorrect or did not include the most recent ICAP evaluation (i.e., Individual #333, Individual #92, Individual #10, and Individual #312). In some cases, it was unclear why the most recent ICAP scores were not included in revised psychological evaluation, especially when the report was completed soon after the ICAP was scored (e.g., Individual #312). In addition, it was unclear why ICAP evaluations would be conducted after the psychological assessment was completed and thereby preclude any potential to inform the overall assessment (e.g., Individual #10 and Individual #92). Of the psychological assessments reviewed, 22 (100%) contained results of previously completed standardized tests of intelligence. These assessments generally included the use of the Wechsler, Slosson, TONI, and/or Leiter tests and were completed, on average,	Noncompliance

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		approximately 13 years ago (range two to 26 years). Approximately 64% of these IQ tests were conducted over 10 years ago. Only four (18%) of the individuals sampled had standardized tests of IQ and Adaptive Behavior completed within the last five years (i.e., Individual #10, Individual #92, Individual #333, and Individual #300). Lastly, behavioral data was provided in table and/or graph form in the psychological assessment for 10 (45%) of sampled individuals.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	Progress continued to be observed in the area of psychological assessment. To determine whether or not psychological assessments were completed, updated or reviewed as often as needed, documentation provided on 22 individuals was examined. In general, 100% of individuals sampled had completed psychological assessments. However, the assessment for Individual #268 was missing pages two through four. Of the 22 sampled psychological assessments reviewed, 19 (86%) were updated within the last 12 months. However, three of the assessments reviewed were outdated, because they were updated more than 12 months ago (i.e., Individual #275, Individual #307, and Individual #307). When these findings were cross-referenced with the BSC Spreadsheet dated 1/6/11, the findings were consistent for two of three assessment dates. The spreadsheet indicated that a psychological assessment for Individual #275 had been completed within the last year on 3/26/11. In addition, psychological assessments that had been more recently revised and updated appeared to be adhering to the newer format. Overall, 68% of the assessments appeared to be written following the new format. Of the individuals sampled, 17 (77%) had SFBAs that were completed within the last 12 months. SFBAs for five individuals, however, did not appear to have been completed (Individual #244, Individual #311, Individual #70, Individual #118, and Individual #92). There were no new individuals admitted to CCSSLC within the last six months. Therefore, examining the timeliness in which psychological assessments were completed following admission was not necessary.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Limited progress was noted in the area of provision of psychological services, that is, services beyond those associated with PBSPs. As reported at the time of the July 2010 review, there was only one community-based therapist contracted through CCSSLC to provide counseling services to individuals identified as needing counseling. At the time of the most recent review, two counselors were providing counseling services to 16 individuals living at CCSSLC. This was an improvement in the availability and access to counseling services. At the time of the July 2010 review, it appeared as though the contracted therapist had	Noncompliance

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		developed individual goal(s) for each individual receiving therapy. For many of these individuals, however, the developed goals did not appear to be clear, objective, or measurable. In addition, based on the information provided, it was unclear if any baseline or ongoing data was being collected to evaluate whether or not progress was being made. Lastly, treatment plans were not provided as requested. Therefore, it was not possible at the current time to determine whether or not counseling services employed evidenced-based practices. At the time of the most recent review, some limited progress had been made since the last monitoring visit to address the issues identified above. Measureable objectives were written recently (December 2010) for 10 (63%) of the individuals identified as receiving counseling. It was unclear if objectives for the remaining six individuals had been written (i.e., they were not included with other provided documentation). Upon review, these objectives: 1) included the same, seemingly arbitrary goal date for all individuals (August 31, 2011); 2) were at times vague in identifying specific overt responses (e.g., Individual #275 will "… successfully identify anger triggers and demonstrate three appropriate responses …"); and, 3) set a relatively inflexible and extended success criteria (i.e., "… for three consecutive months"). In addition, these goals did not appear to be part of a larger treatment plan. Rubrics had been developed to standardize the referral, treatment, and monitoring of counseling services. More specifically, rubrics including a Counseling Referral Form, Counseling Treatment Plan, and Counseling Progress Note were provided. It was unclear if all of these forms have been formally implemented. According to the POI, on 12/16/10, "new treatment plans have been developed." The Monitoring Team assumed that this referred to the development of the new treatment plan format, because no treatment plans related to counseling were noted. Because treatment plans were not available, the Monitoring Team was not able to determine if treatments utilized during counseling sessions were evidence-based. Similarly, other critical elements central to effective treatment program (i.e., "fail criteria," generalization strategies, etc.) could also not be established. A selection of case notes were provided for nine of the 11 individuals listed as receiving counseling services. Review of these notes indicated that the majority seven (78%) adhered to the above prescribed structure (Counseling Progress Note). Of these individuals with case notes provided, two (22%) were selected to examine the role of the psychologist and the larger PST, as well as to assess monthly monitoring. ▪ The psychological assessment, dated 3/27/09, did recommend to "… continue community counseling with licensed counselor." So, it appeared that at the time the assessment was completed, Individual #275 was already receiving this service. However, this recommendation or any reference to community-based	

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		counseling services was not found within her PSP, dated 4/22/09. Recommendations to continue with outside counseling did appear frequently across time within PSP addendums. In addition, Individual #275 did have an integrated goal that she worked on during counseling sessions, as well as within a skill acquisition program (i.e., targeting anger management). Lastly, PSP monthly notes included reference to the counseling sessions (e.g., "[she] continues to see a counselor in the community and is responding well to her"), although these comments did not promote data based decision-making. ▪ Review of the psychological assessment, dated 8/10/10, and PSP (dated 11/9/10) for Individual #246 did not reveal any evidence of discussion or recommendation regarding community-based counseling services. In addition, no support for counseling services was found in available PSP Addendums or PSP Monthly reviews. The current CCSSLC Psychological Care and Services: Counseling policy highlighted the importance of timeliness regarding the provision of psychological services once a need was identified. According to the policy, counseling was to be initiated within two weeks of the referral by the PST (or immediately if an emergency). At the current time, it was unclear if referral and initiation dates of counseling were readily available. Documentation, however, indicated that, in addition to the PST, referrals were now reviewed and monitored through the BSC. Given that there was a new BSC Spreadsheet, monitoring should occur to determine when referrals are made and when counseling sessions are initiated. Lastly, the POI indicated that a supervising psychologist would be assigned to serve as liaison between community-based counseling providers and CCSSLC. Verbal reports indicated that this new liaison likely would be a newly hired psychologist. Future reviews will need to examine how well this liaison bridges these two systems and supports effective treatment and monitoring. As previously reported, in addition to counseling services, other types of therapeutic services had been observed during on-site visits. These included sensory rooms where individuals were offered opportunities to experience different sensory stimulation across many modalities (visual, tactile, olfactory, etc.). Other environments included, for example, the Comfort Zone and Snoezelen Room where individuals were encouraged to participate in other formal or informal programs and activities. As recommended in the past, if such settings are designed to assist in providing individuals with therapy or treatment, then specific outcomes should be identified for each individual, and data collected and reviewed to determine the therapy's effectiveness on an individualized basis. In response to this recommendation, the Director of Active Treatment recently created a position to support the identification, procurement/development, and implementation of	

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		evidenced-based assessments and treatments for individuals with Autism. This position will be integral in training and educating other staff as well as collaborating with other professionals and disciplines. Verbal reports indicated that a professional with experience working with adults with Autism was recently hired. Subsequent review by the Monitoring Team will examine the progress that this new professional makes in addressing previous recommendations.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Some progress had been made in the area of PBSPs. Since the last visit, policies targeting the development, review and ongoing monitoring of PBSPs that had been previously revised and approved were implemented and trained. In addition, a new PBSP format was revised and 100% of Psychologists (14) had been trained, on 10/14/10, in using the new rubric when developing PBSPs. In addition, a new electronic spreadsheet, referred to within this report as the BSC Spreadsheet, had been created to track all of the dates associated with documents (e.g., psychological assessments, SFBAs, and PBSPs) completed by behavioral services staff. As of 12/1/10, staff had begun to "populate" this spreadsheet with all the related dates. This spreadsheet will assist behavioral services staff in monitoring important dates as well as provide a useful tool to reduce delinquent approvals, consents, etc. Requested documentation, including the HRC Review of BSP form, BSC Review and Approval Form, Consent to Treatment-Therapy form, and Training Documentation on PBSPs, as provided, was reviewed to ensure that consents and approvals for PBSPs were obtained prior to their implementation. Fifteen individuals with PBSPs were selected from provided documentation and, of this sample, 100% and 87% appeared to have completed the necessary BSC and HRC approvals, respectively. The HRC approval forms were not available and over a year old for Individual #275 and Individual #300, respectively. Also, the Consent for Treatment Form appeared to be adequate for 12 (80%) of the individuals sampled. More specifically, the Consent for Treatment Form was missing for Individual #255, over a year old for Individual #300, and appeared to be completed after the other consents (BSC and HRC) were completed and after the PBSP was implemented for Individual #268. Two recent systems had been developed to assist with ensuring necessary consents were obtained, including: 1) the BSC Spreadsheet, as described above; and, 2) a new BSC Review and Approval Cover Sheet. This cover sheet was to be utilized to monitor reviews and approvals of psychological evaluation/updates, SFBAs, and PBSPs. This cover sheet was quite impressive as it prompted questions regarding the quality of the content of each assessment or plan. This reflected an improvement over the last BSC cover page. As previously presented, progress had been made in the area of PBSPs. Since the previous Monitoring visit in July, Behavioral Services staff members had participated in multiple trainings related to: 1) the implementation of revised and approved policies	Noncompliance

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		within Psychological Care and Services; 2) changes in formats of assessments and plans (i.e., psychological assessments/updates, desensitization plans, PBSPs, and SPCIs); and, 3) trainings related to Applied Behavior Analysis (e.g., basic functions of behavior, prevention of and responding to behavior, and replacement behaviors). With the understanding that format of PBSPs had been revised repeatedly over the past year, including one very recent revision, it was expected that changes in the format and content of PBSPs over time would be observed. In an attempt to avoid examining formats that had already been changed, PBSPs that had been developed or revised in the last few months were selected for review. Behavioral services staff had been trained on all of the revised formats three months prior to the Monitoring Team's review. As described below, there were two exceptions to this effort as not a sufficient number of requested PBSPs met the criteria. In the end, 10 PBSPs were examined. These included Individual #145, Individual #251, Individual #7, Individual #92, Individual #300, Individual #243, Individual #246, Individual #118, Individual #47, and Individual #268. Of the PBSPs reviewed, four (40%) were completed using the most recently revised format (i.e., Individual #145, Individual #251, Individual #300, and Individual #243). This format was much more concise, straightforward and simple compared to the previous version. It appeared much easier for staff to read, comprehend, and utilize, thereby, increasing the likelihood for greater treatment integrity. Comparison of the two formats indicated that the new revision retained previously identified critical components. More specifically, the new format provided highlights of medical and psychiatric issues, operational definitions of target and replacement behavior, potential function(s) of behavior, antecedent-based (preventative) and consequence-based strategies, teaching strategies to promote replacement behaviors and weaken undesired behaviors, data display, and an area to document signatures. The new format, however, did not include some critical components, including information on prior interventions and related outcomes, reminders to utilize reinforcement, specification regarding data collection, or procedures to reduce the intensity of the intervention. The review of sampled PBSPs revealed common concerns across formats. As it turned out, changing formats did not eliminate all the previous challenges discovered when writing plans in the old format. The most consistent and problematic concerns are described below. The majority of these issues were discussed within previous Monitoring reports. It appeared that behavioral objectives continued to be difficult to write or staff did not understand what was expected. For example, the behavior objective for Individual #300 stated: "the purpose … is to reduce aggression and increase ability to utilize alternative ways to communicate anger." Behavioral objectives are not typically general goals, but	

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		rather measureable objectives. More intensive training should be provided on writing acceptable behavioral objectives. Also, additional or more specific instructions should be added to the revised PBSP rubric to remind staff of the necessary components of adequate behavioral objectives. Some PBSPs continued to reflect difficulty in operationally defining target behaviors. For example, the definition of aggression for Individual #300 included "… reacting angrily to others, typically verbally, but sometimes physically, making threats or performing acts of violence." This was subjective and likely difficult to measure with accuracy. The definition of self-injurious behavior (SIB), however, was very well done for Individual #243. However, the additional information contained within the section (regarding function) would best be placed within the section devoted to function of target behaviors. PBSPs developers also struggled with replacement behaviors. It appeared that many psychologists continued to have trouble identifying (labeling) and operationally defining replacement behaviors. Interestingly, improvement was noted in writing clearer, more objective definitions of target behaviors. The same needs to happen with replacement behaviors. For example: ▪ The replacement behavior for Individual #145 actually appeared to be targeting staff behavior. It stated: "Teach [her] to use her communication board to resolve issues and explain what she wants or needs." In fact, the replacement behavior appeared to change, because later in the plan it stated: "(she) will identify her feelings …" Obviously, the definitions need to be objective and target the Individual's overt responses. ▪ The replacement behavior for aggression for Individual #300 was described as "alternatives ways to communicate anger." More specificity with examples of acceptable responses would be helpful to staff. Similar concern was noted for Individual #118. Her replacement behavior was defined as "(she) will be able to identify and utilize replacement behavior of identifying feelings and using problem solving skills." ▪ The replacement behaviors described in the PBSP for Individual #243 appeared to be behavioral objectives. Staff should be provided more intensive training in the area of writing operational definitions. The method and resulting outcome of writing these definitions should be the same regardless of whether staff members are developing them for behavior to increase or decrease. Considerable difficulty remained in demonstrating the link between assessment and intervention. More specifically, the interventions often found in PBSPs did not appear related to the findings of recent SFBAs. For example:	

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		▪ The function described within the PBSP of Individual # 145 stated that "… (her) objective was to learn to communicate her emotions using her communication board that than (sic) engaging in disruptive behaviors." There was no indication at all of the functions (access to tangibles, escape) identified in her SFBA. ▪ The Summary of Function section describes the goal of the PBSP as "the purpose of her current PBSP is to reduce disruptive episodes and increase ability to utilize relaxation techniques when upset/angry," which was not the underlying function identified by the SFBA for Individual #251. ▪ The functions identified in the SFBA (i.e., access to tangibles, attention) were not identified in the Summary of Function section of the PBSP for Individual #300. ▪ The description of the function (of self-injury) found in the PBSP for Individual #243 was very well done. Psychology staff should be provided more intensive training related to the importance of assessment informing intervention. It is critical that staff understand that assessment findings should direct treatment. That is, the findings from the SFBA should facilitate hypotheses about target behaviors and treatment should be linked to addressing each of those hypotheses. It is likely difficult for assessment to inform treatment when the assessment was completed after the PBSP was developed (i.e., Individual #10 and Individual #109). In addition, treatment history should be concisely highlighted (either in the PBSP or SFBA), as this supplements current assessment findings and shapes the nature of future interventions. For example, the history of one individual (Individual #7), as outlined in her SFBA, appeared to be helpful in determining current interventions. Reviewed PBSPs typically endorsed the use of verbal praise and/or campus bucks. More individualized reinforcers were not commonly prescribed. When other reinforcers were included, their description was typically very general or non-specific. For example: ▪ The reinforcers provided after "every session" of a teaching program included "campus bucks" or "preferred non-restricted items." More specification might be helpful to staff unfamiliar to Individual #7. In addition, it might be more effective to provide the reinforcer after correct responding and not after every session. ▪ Similarly, it might be more meaningful if the reinforcers identified for Individual #92 were more specific than described as "positive reinforcement items." In one out of four different teaching strategies within the PBSP, reinforcers were prescribed following correct responding (i.e., not just effort). ▪ Campus bucks were identified in the material section as necessary for the skill training program related to the replacement behavior for Individual #300, but reinforcement procedures were not included in the related teaching strategies.	

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		Formal preference assessments should be completed on a regular basis. Findings should then be integrated into formal skill programming, incidental teaching opportunities, and antecedent-based interventions. In addition, as appropriate, highly preferred reinforcers should be used for correct responding and perhaps less preferred reinforcers for good effort. As similar to the last review, in some plans, preventative or antecedent-based approaches more closely resembled reactive or consequence-based approaches. For example: ▪ As described in the PBSP for Individual #300, the preventative approaches were all framed as redirection, following agitation or the target behavior. ▪ The prevention strategies offered within the PBSP for Individual #47 were clearly describing procedures that occur after aggression. ▪ Similarly, the outlined strategies for SIB for Individual #268 were implemented only after he had begun to demonstrate the target response. Ideally, this would involve the utilization of preventative or proactive approaches prior to the occurrence of the target response. Some of the knowledge gained from identifying setting events through the SFBAs should be integrated. As described, the new formats were much simpler and straightforward. This appeared highly likely to facilitate better understanding and perhaps improved treatment integrity. It was surprising how redundant some of the content was in previous plans (e.g., Individual #246). Efforts should be made to remain vigilant and eliminate the repetition of content within plans or across documentation, when appropriate.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	At the time of the Monitoring Team's review, inter-observer agreement (IOA) for PBSP data was not being collected. This was consistent with previous findings at the Baseline and July visits. As a result, the accuracy of the data could not be assured. As discussed above with regard to Section K.4 of the SA, there were concerns related to the collection of accurate and reliable data. As presented in previous Monitoring reports, the availability of data that PSTs can have confidence in is essential in ensuring that teams are making effective data-based decisions. Psychology and behavioral services staff, including the Clinical Psychologist, continued to acknowledge the value in collecting this data. Discussion indicated a desire to start small and potentially pilot one or more methodologies and examine which was effective and efficient in collecting sufficient reliability data, as well as acceptable and feasible to behavioral service staff. It should be noted that a CCSSLC policy regarding the collection of IOA data, entitled Psychological and Behavioral Services - Measurement and Analysis of Effectiveness of Positive Behavior Supports, was implemented on 8/9/10. Although the policy promoted	Noncompliance

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		the examination of reliability and treatment integrity, it was vague in prescribing how these measures would be conducted. For example, with regard to IOA, it was unclear with regard to: 1) Do new staff members need to meet the IOA criterion of 80% for every individual across every behavior being tracked; and, (2) Do they need to meet that criterion prior to collecting any data? In addition, with regard to treatment integrity, the policy indicated a "daily review" of staff's understanding of the PBSP. It was unclear if this daily review was a quiz that estimated staff's knowledge of PBSP, or actual direct observation that estimated staff's ability to implement prescribed interventions correctly. Like previous policies, this newly implemented policy is likely to be revised as CCSSLC staff begin to evaluate and refine the practice of examining IOA and treatment integrity. According to verbal reports, although the PSP process was to transition to quarterly meetings to review programs, skill program data would continue to be reviewed on a monthly basis. At the last review, it was found that skill acquisition data was just starting to be displayed in graphs for a few individuals at CCSSLC. Currently, based on a review of available PSP Monthly Reviews for 22 sampled individuals, 21 (95%) had at least one month where skill acquisition programming data was display via graph. Although the one exception, Individual # 305, did not have skill program data graphed, behavioral data was graphed and displayed with his PBSP. Presenting data using graphic display had become commonplace. Based on provided documentation, graphing behavioral as well as skill acquisition data now appeared routine. It was found within assessments, interventions, and/or monthly PSP reviews across a very high percentage of individuals reviewed. However, as presented earlier with regard to Section K.4 of the SA, there were still some concerns regarding the quality of the graphs. These concerns were not new as most were consistent with issues described following the Monitoring Team's previous visit. Concerns with graphic included: 1) displaying multiple types of data (e.g., frequency, percent, milligram) on a single Y-axis; 2) dark backgrounds or color data paths that did not copy well; 3) not labeling axes, especially multiple Y-axes; 4) compressed data range for one variable due to the very large range of a second variable (usually medication dosages); 5) the inclusion of too much data on one graph; 6) including data on graphs that has not been defined; and 7) using bars/columns in place of line graphs. Corresponding examples included: 1. The efficient and effective interpretation of replacement behavior was often limited by using a single Y-axis. This was found in many graphs (e.g., SFBA for Individual #255 or psychological assessment of Individual ##268). More specifically, the use of percentage data restricted the range of replacement behavior data between zero and one on the Y-axis.	

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		2. The varying colors used representing multiple variables were difficult to perceive after copying (e.g., PSP Monthly Behavioral Services review for Individual #300). Similarly, the dark field background of some graphs made interpretation more challenging (e.g., graph in PBSP of Individual #251); 3. The graph displayed in the psychological assessment for Individual #246 was difficult to interpret as the multiple Y-axes were not labeled. A similar finding for Individual #251 was made. Occasionally, data was unclear and interpretation was difficult even when both axes were labeled (e.g., psychological assessment for Individual #7); 4. The graph included in the PBSP for Individual #311 displayed a Y-axis with an extended range (zero to 300) to accommodate the high dosage of medication (Seroquel). As a result, this made visual analysis of the other variables (e.g., tantrums, replacement behavior) more challenging. Similar concerns were noted with the PSP Monthly Behavior Services Review for Individual #275. The design of the included graph limited ease of interpretation due to the extended range of the Y-axis (zero to 60) due to the high dosage of medication (Pristiq); Subsequently, the interpretation of the other behaviors (aggression, SIB, etc.) was more difficult. Other examples included the graph in the PBSP for Individual #47; 5. The efficient and effective interpretation of graphs was limited by the display of too many variables (e.g., graph in the PBSP of Individual #47 or Individual #275, as well as graph in PSP Monthly Behavior Services Review for Individual #246 or Individual #118); 6. The graph included in the SFBA for Individual #246 included a target behavior (spurious allegations) that was not defined within the PBSP. Similarly, an additional variable ("antecedent") was included in the graph in the SFBA for #145, but was never defined or explained; 7. The use of multiple bars and lines within the graph in the PSP Monthly Behavioral Services Review for Individual #275 inhibited interpretation. Accepted practice generally includes the use of line graphs, not bar graphs, when displaying data. Visual analysis (e.g., determining trends, identifying disruptions or changes in treatment, etc.) is facilitated when data points are connected across time. Similar concerns were noted in the graphs displayed in the psychological assessment for Individual #311. In this case, the graphs were not well positioned within the page as well. This made interpretation very difficult. Bars/columns within graphs are less preferred to other forms of data display, especially when other formats have effectively displayed information related to medications (e.g., PSP Monthly Reviews for Individual #286). Indeed, the use of both columns and lines in some graphs (e.g., graphs in the SFBA for Individual #348) inhibit interpretation. If the Facility continues to utilize a combination of lines and columns within graphs, lines and columns should be used to display	

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		target behaviors and medication dosages, respectively. In these cases, graphing on a single axis and the use of multiple colors that interfere with effective interpretation (when copied) should be avoided. As recommended at the previous review, psychology staff should: 1) accurately label both axes; 2) use multiple graphs or eliminating unnecessary data; 3) illustrate data differently (e.g., providing medication dosages in tables below graphs), when appropriate; 4) use multiple Y-axes to display different dimensions of behavior; 5) utilize phase/condition change lines to demarcate changes in treatment or other significant changes in functioning; 6) avoid using color to differentiate between variable as graphs will ultimately be copied; and, (7) avoid using bar/columns within graphs.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	It appeared that some progress had been made in revising the format of PBSPs, and subsequently increasing the likelihood of better comprehension and treatment integrity by direct care staff. Since the previous visit in July, CCSSLC adopted the State Office PBSP template, which was significantly shorter and easier to read. As previously reported, PBSPs tended to have an average length of approximately 11 to 12 pages, with a range from six to 19 pages. At the time of the most recent review, based on a review of four PBSPs developed using the new template, the average length was approximately seven to eight pages, with a range of six to nine pages. Behavioral Services staff members developed their own abbreviated PBSP summary format ("cheat sheet") that they had integrated within a typical data sheet with data on the front, and abbreviated PBSP content on the back. According to the verbal reports from behavioral services staff, this new cheat sheet was trained and implemented just prior to the Monitoring visit in December 2010. In upcoming visits, the Monitoring Team will be interested in reviewing and learning more about the effect this abbreviated summary has had on staff's ability to remember and implement PBSPs. As previously reported, since April 2010, the Facility had been using the "Competency Check for Behavior Support Plan" to assess both staff knowledge and overt responding through observation or interview. This rubric examined how knowledgeable a particular staff member was regarding a randomly selected PBSP, including the ability to identify challenging behaviors and potential functions, replacement behaviors, antecedent and consequence-based interventions, as well as point out medications, and explain data collection procedures. According to verbal reports, these random checks continued to be completed twice a day by the psychologist on-call. Although data had been collected using this new tool for some time, according to staff reports, the data had not yet been sufficiently analyzed. This finding was consistent with the results from the previous Monitoring visit. That is, no summary data was available to examine at that time or presently. Consequently, there was no evidence to review at the current time. The	Noncompliance

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		Monitoring Team looks forward to examining the summary data, including process as well as outcome data, from these checks during the next on-site visit. In an effort to evaluate staff knowledge of PBSPs, direct observations and discussion with direct support professionals were conducted across residential programs during the recent on-site visit. These interviews produced mixed results in the accuracy of staff's responses regarding general knowledge of individuals served, as well as specific information regarding behavioral programming and data collection. For example: ▪ A direct support professional was able to correctly identify the target behaviors (i.e., noncompliance, SIB, and aggression) and an appropriate consequence-based strategy for SIB in response to questions about Individual #268. ▪ When asked about responses to target behaviors of Individual #7, the Home Team Leader correctly described basic problem-solving skills that are part of her replacement behaviors. ▪ An experienced active treatment specialist had difficulty naming any current acquisition programs for Individual #307, and when asked about target behaviors within the PBSP, named two responses, which were not in the plan. ▪ When asked which skill program Individual #77 had the most success with, an experienced staff member had initial difficulty identifying a single program. Following further prompting, the staff eventually named one of the current programs. ▪ A direct support professional had difficulty accurately discussing how a daily skill acquisition program was scored, but was successful in globally describing effective interventions prescribed in the PBSP for Individual #243. As previously stated, findings were mixed and consistent with previous Monitoring Team visits regarding staff knowledge of behavior programs. At times, staff appeared comfortable in discussing the PBSPs and skill programs of select individuals. Other staff, however, continued to rely on obtaining documentation prior to answering the Monitoring Team member's questions. In addition, there were several occasions where staff did not immediately offer answers to simple, straightforward questions. This was surprising as this is the type of knowledge that experienced staff working directly with individuals on a daily basis would be expected to know. Without such knowledge, they cannot provide adequate protections and supports to individuals to whom they are assigned.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all	No appreciable progress was noted in the area of competency-based training. In an attempt to verify that current staff had been trained on specific PBSPs and SPCIs, requested training documentation was examined. The current sample included 15 PBSPs	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	and seven SPCIs. Provided documentation indicated that 73% and 57% of PBSPs and SPCIs sampled, respectively, appeared to have offered trainings to direct care staff. Closer examination of 12 (56%) randomly selected individual training documents (for PBSPs and SPCIs) indicated that 67% occurred on a single date, 25% occurred across multiple dates, and one training did not contain a date. In addition, only two (17%) recorded the duration of training. The two training documents that listed the duration indicated that training occurred for approximately 15 minutes (for the PBSP of Individual #311) and 30 minutes (for the PBSP for Individual #145). Lastly, the average number of staff trained on a specific plan appeared to be approximately 17 with a range of five to over 30 in attendance. This limited number of trained staff (only five signatures on the training document dated 8/3/10) on the PBSP for Individual #325 was concerning. Given that staff did not date the form when they sign, it was difficult to assess when they were specifically trained. In some cases, when multiple training dates were indicated on the form, it was apparent that multiple trainings were offered, but not who attended which training. An improvement noted on one training document (i.e., PBSP training dated 11/17/10 for Individual #246) included the use of signature sheets with staff names pre-printed. This allowed quick assessment of who still required training. This would assume, of course, that every staff member working with a particular individual was listed. Verbal reports indicated that staff trainings continued to incorporate active learning strategies (e.g., modeling, rehearsal, repeated practice, etc.) during trainings. These types of strategies were highlighted in recently implemented Psychological and Behavioral Services Positive Behavior Support Plan and Competency Based Training for PBSP policies. Unfortunately, however, direct observation of trainings still has not occurred during a monitoring visit. Specific requests to observe scheduled PBSP trainings will be made during upcoming monitoring visits. The POI indicated that competency-based training targeting SPCI and PBSPs was recently initiated on 12/13/10. Provided documentation did evidence the availability of rubrics designed for the assessment of staff competency on collecting behavioral data (including skill acquisition or replacement) as well as on the implementation behavioral programming. According to verbal reports, however, data reflecting the use of these rubrics was unavailable for review. This was consistent with the current document review as no evidence was found indicating that competency-based trainings or that staff competency was examined following training. According to the POI and verbal reports, a workgroup had recently been developed and charged with more closely examining the nature of competency-based training across the entire Facility and determining an effective method of measuring related outcomes. A simple measure should be developed that supervising psychologists can use while observing a psychologist or psychologist assistant while conducting a PBSP training, for example, to examine whether or not	

#	Provision	Assessment of Status	Compliance
		elements critical to effective teaching (active learning strategies) are integrated within the training. The Monitoring Team was still unclear on how the Facility monitors and ensures that staff, especially pulled and relief staff, receive competency-based training on the PBSPs that they will be responsible for implementing. Further review of system(s) designed to ensure that direct support professionals are competent in implementing PBSPs across settings will be reviewed further during upcoming monitoring visits. Overall, the provision of adequate training in the area of PBSPs and SPCIs continued to be a serious concern.	
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.	Currently, based on documentation provided, there were 14 Associate Psychologists, in addition to the Clinical Psychologist, and five Psychology Assistants. None of these professionals currently held BCBAs. Of note, this recent information was inconsistent with verbal reports as well as data presented within the POI, which indicated that an additional one part-time and two full-time Psychology Assistants were hired, but had not yet started at the time the POI was written. Likely, but the time of the review, they had begun employment. This would reflect a total of 7.5 Psychological Assistants. As of the most recent on-site review, CCSSLC served 283 individuals. Based on this number and the understanding that the Clinical Psychologist would not carry a caseload, an approximate average psychologist-to-individual ratio was 1:20. In addition, given the provided documentation, there appeared to be less than two psychological assistants for every associate psychologist employed. However, based on verbal reports, it was likely that the documentation was outdated and did not accurately reflect recent hires. However, as noted with regard to Section K.1 of the SA, this provision was rated as in noncompliance because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as required by the SA as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Behavioral services staff should continue to be encouraged to enroll in graduate coursework toward their BCBA. This includes continuing to identify and ameliorate, if possible, reasons why the remaining staff members are reluctant to take graduate coursework.
2. Efforts should continue to hire a Director of Behavioral Services and Chief Psychologist. Serious consideration should be given to recruiting and hiring a professional with his/her BCBA.
3. CCSSLC should continue to implement, monitor, and refine the newly approved Psychological and Behavioral Services Policies.

4. Efforts should continue to be made to attract additional BCBA-level professionals to assist with review of psychological assessments, skill acquisition, and behavioral programming. This includes the continued effort to develop a supplemental external peer review committee, comprised of BCBA professionals from other Texas facilities or elsewhere that would offer alternative perspectives, evaluations, and feedback on perhaps more restrictive or intrusive behavioral programming.
5. CCSSLC should ensure that the contracted BCBA professional has sufficient time to adequately supervise staff members enrolled in coursework according to supervision guidelines outlined by the Behavior Analyst Certification Board (BACB). Emphasis should be placed on initiating supervision of all enrolled student.
6. Policies and/or procedures should be developed and implemented that would ensure more consistent adherence to BSC scheduled meeting dates. With the significant number of evaluations and programs that require review, it is important to reduce the likelihood that meetings would be cancelled.
7. In addition, such a policy/procedure should list all of the participants expected to attend BSC meetings.
8. As recommended previously, given the significant number of assessments and plans (PBSPs, SPCIs, and Desensitization) that require annual (at a minimum) review, a process should be established that ensures sufficient time for adequate review. That is, a hierarchy should be developed for behavior plans (perhaps based on restrictiveness, intrusiveness, severity of target behaviors, etc.) that would prescribe more or less time or, perhaps, comprehensiveness or frequency of review dependent upon where the plan falls on this hierarchy.
9. Efforts should continue to develop a supplemental external peer review committee comprised of professionals not employed by CCSSLC. Membership of this committee should include professionals who are board certified in behavior analysis. This committee would potentially meet less often than the BSC, but would likely offer alternative perspectives, evaluations, and feedback on perhaps more restrictive or intrusive behavioral programming.
10. Efforts should continue to populate the BSC Spreadsheet. Based on regular review of this spreadsheet, staff should be provided feedback regarding identified delinquencies, and this feedback should be documented.
11. Additional training should be provided on the concept of setting events, across all behavioral services staff. In addition, psychologists might require additional direction and/or training in resolving situations where assessments might not provide clear findings. In these cases, additional assessments might need to be completed.
12. Raw data collection systems should be individualized. A review of the nature of target and replacement behaviors should be completed, and consideration given as to whether or not an alternative or supplemental data collection methodology might be more appropriate and/or would provide more meaningful data (i.e., scatter plot, ABC data, partial interval, duration recording, measure of intensity, etc.). Changes to the system should be weighed against potential negative effects of multiple or increasingly diverse data collection systems, as well as the systems' acceptability and feasibility as judged by those collecting the data.
13. When findings from rating scales are inconsistent, additional indirect and/or direct assessments should be completed.
14. With regard to SFBAs, expectations should be established to clearly identify the information that is required, the level of detail that would be helpful, and encouraging summarization and integration of information, when possible. A section could be added on treatment history (if not better suited to the PBSP).
15. Given that there was a new BSC Spreadsheet, monitoring should occur to determine when referrals are made and when counseling sessions are initiated.
16. All recommended psychological services, including but not limited to psychological counseling, should be identified within the psychological assessment and PSP. In addition, these services should be goal-directed, include measureable outcomes, and treatments should be evidenced-based. These might best be evidenced through the use of a comprehensive treatment plan.
17. Individuals who provide therapeutic interventions should be qualified to do so through specialized training, certification, or supervised practice.
18. As previously recommended, data should be collected on the use of any intervention conceptualized, described or utilized as therapeutic (or therapy). This data should facilitate the examination of whether or not the identified therapeutic intervention is effective. In addition,

therapeutic interventions should include goals with measurable objectives, outline treatment expectations, and provide sufficient content describing the intervention so that determinations of whether or not procedures reflect evidenced-based practice can occur. Then, psychological and behavioral services staff as well as the PSP team can determine whether or not the time and resources spent on these therapies are effective.

19. The empirical support should be reviewed for any therapies provided to individuals served by CCSSLC whether on or off campus. In addition, PSP teams with the assistance of the new Autism Specialist should consider whether or not other evidenced-based practices (e.g., functional communication training, picture exchange communication system, etc.) might be a better match to address the underlying needs of those identified.
20. As recommended in previous reports, collaborative efforts across disciplines (e.g., psychology and active treatment services) should continue to ensure that each discipline's strengths are utilized to improve current supports and services. Special consideration should be given to promoting the effective collaboration between speech services and psychology. Collaborative efforts should include, for example, identification and implementation of supplemental assessment methodologies or intervention strategies. Indeed, efforts should avoid redundancy of services. An indirect service model might be appropriate, given limitations within speech/language services, involving, for example, "train-the-trainer" in-services where speech professionals teach psychology staff how to conduct an ABLLS assessment or implement FCT or PECs.
21. A brief section on history of previous interventions as well as reducing restrictiveness should be added in the new PBSP template. If treatment history cannot be added concisely, consider integrating the information in the SFBA (see Recommendation #14). It is important to provide a background on ineffective procedures as well as specific criteria (clear objectives) of behavioral progress (or deterioration), including target and replacement behaviors, which would identify when team reviews or PBSPs revisions would be considered.
22. In addition, the new PBSP format should include reminders to utilize reinforcement, specification regarding data collection, or procedures to reduce the intensity of the intervention
23. Peer reviews of PBSPs should continue to determine if target and replacement behaviors are operationally defined, prescribed interventions address identified hypotheses, if replacement behaviors are functionally equivalent, and whether or not antecedent interventions are truly preventative in nature. In addition, they should examine whether or not the use of reinforcement is conspicuous and if reinforcers are individualized.
24. As recommended in previous reports, with regard to reinforcers:
    a. Use of positive reinforcement should be enhanced across antecedent and consequent-based intervention strategies;
    b. Reinforcers should be as individualized as possible; and
    c. As appropriate, differential reinforcement should be utilized. That is, provision of reinforcer (and/or quality of reinforcer) should be dependent upon the accuracy of responding.
25. In addition to previous recommendations regarding reinforcers, formal reinforcer/preference assessments should be completed with regularity and findings should be integrated within skill acquisition programs and PBSPs.
26. A system should be developed for assessing and monitoring inter-observer agreement for PBSP data. It might be helpful to approach this as a pilot program. More specifically, this data should be collected, examined and analyzed on a select number of individuals or with a few programs before implementing it system-wide.
27. On behavioral graphs, just as target behaviors are labeled (e.g., aggression, SIB, etc.), replacement behaviors should be labeled, and similarly and conspicuously operationally defined.
28. Replacement behaviors should, in addition to formal teaching sessions, be monitored and tracked as they occur in the natural environment. As this additional data is collected, it should be integrated into monthly graphs.
29. In an effort to facilitate more efficient and effective visual analysis of graphs, psychologists should:
    a. Accurately label both axes;
    b. Use multiple graphs or eliminating unnecessary data;
    c. Illustrate data differently (e.g., providing medication dosages in tables below graphs), when appropriate;

d. Use multiple Y-axes to display different dimensions of behavior;
e. Utilize phase/condition change lines to demarcate changes in treatment or other significant changes in functioning;
f. Avoid using color to differentiate between variable as graphs will ultimately be copied; and
g. If the Facility continues to utilize a combination of lines and columns within graphs, lines and columns should be used to display target behaviors and medication dosages, respectively. In these cases, graphing on a single axis and the use of multiple colors that interfere with effective interpretation (when copied) should be avoided.

30. Treatment integrity data should be collected, summarized, and examined. The collection of this data is necessary to ensure confidence that programs are implemented as written.
31. Staff trainings of skill acquisition programs, PBSPs, and SPCIs should be examined to ensure that the methodology utilized incorporates critical elements of competency-based training. If not already in place, a simple measure should be developed that can be completed by an observer (e.g., supervising psychologist) during the training that estimates whether or not these components were integrated within the training.
32. Ongoing competency check data should be examined. This should include determining the adequacy of the regular monitoring as well as what steps were taken (or need to be taken) to ensure adequate integrity of PBSP implementation.
33. A system or training log should be developed, adequately maintained and readily stored at each residential program that allows supervisory staff to determine quickly if pulled or relief direct support professionals have the necessary training to work at the site, and/or with specific individuals.

The following are offered as additional suggestions to the State and Facility:

1. Consideration should be given to how CCSSLC will respond to Behavioral Services staff members how do not adhere to the expectation and stated policy related to enrolling in graduate coursework related to Applied Behavior Analysis.
2. Consideration should be given to including the review of Safety Plans for Crisis Intervention within the CCSSLC Psychological Care and Service – System to Review Quality Policy.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: o **Review of Following Documents**: o Medical records for: Individual #379, Individual #58, Individual #131, Individual #180, Individual #311, Individual #340, Individual #19, Individual #67, Individual #43, Individual #22, Individual #159, Individual #355, Individual #179, Individual #183, Individual #310, Individual #70, Individual #153, Individual #24, Individual #207, Individual #270, Individual #307, Individual #284, Individual #348, Individual #75, Individual #239, Individual #188, Individual #320, Individual #211, Individual #7, Individual #152, Individual #87, Individual #333, Individual #228, Individual #173, Individual #240, Individual #68, Individual #316, Individual #136, and Individual #380; o List of individuals with scabies, dates of diagnosis since 12/9/10; o CCSSLC Rash response timeline, dated 12/8/10; o Centers for Disease Control (CDC) Treatment: Suggested General Guidelines, last updated 11/2/10; o Annual medical assessments and physical examinations for the following: Individual #186 annual medical assessment completed 12/11/09, physical exam completed 12/11/09, and annual medical assessment completed 12/14/10, physical exam completed 12/14/10; Individual #47 annual medical assessment completed 11/20/09, physical exam completed 11/20/09, and annual medical assessment completed 11/29/10, physical exam completed 11/29/10; Individual #119 annual medical assessment completed 11/11/09, physical exam completed 11/11/09, and annual medical assessment completed 12/27/10, physical exam completed 12/27/10; Individual #9 annual medical assessment completed 11/12/09, physical exam completed 11/12/09, and annual medical assessment completed 11/18/10, physical exam completed 12/30/10; Individual #103 annual medical assessment completed with two different dates 6/24/09 and 11/18/09, physical exam completed 11/18/09, and annual medical assessment completed 12/3/10, physical exam completed 12/6/10; Individual #212 annual medical assessment completed 11/24/09, physical exam completed 10/28/09, and annual medical assessment completed 12/8/10, physical exam completed 12/30/10; Individual #174 annual medical assessment completed 11/19/09, physical exam completed 11/19/09, and annual medical assessment completed 12/21/10, physical exam completed 12/21/10; Individual #124 annual medical assessment completed 11/13/09, physical exam completed 11/13/09, and annual medical assessment completed 11/30/10, physical exam completed 12/8/10; Individual #294 annual medical assessment completed 9/15/09, physical exam completed 9/15/09, and annual medical assessment completed 9/22/10, physical exam completed 9/22/10; Individual #207 annual medical assessment completed 11/18/09, physical exam completed 11/18/09, and annual medical assessment completed 12/1/10, physical exam completed 12/1/10; Individual #157 annual medical assessment completed 11/13/09, physical exam completed 11/13/09, and annual medical assessment completed 11/15/10, physical exam completed 11/15/10; Individual #252 annual medical assessment

	completed 11/16/09, physical exam completed 11/16/09, and annual medical assessment completed 12/6/10, physical exam completed 11/16/10; Individual #158 annual medical assessment completed 12/11/09, physical exam completed 12/11/09, and annual medical assessment not submitted for 2010, physical exam completed 12/13/10; Individual #74 annual medical assessment completed 11/12/09, physical exam completed 11/12/09, and annual medical assessment completed 11/23/10, physical exam completed 11/23/10; Individual #299 annual medical assessment completed 11/16/09, physical exam completed 11/16/09, and annual medical assessment completed 12/2/10, physical exam completed 11/16/10; Individual #317 annual medical assessment completed 11/12/09, physical exam not submitted for 2009; and annual medical assessment completed 11/15/10, physical exam completed 11/15/10; Individual #368 annual medical assessment completed 8/7/09, physical exam completed 8/6/09, and annual medical assessment completed 8/26/10, physical exam completed 8/30/10; Individual #209 annual medical assessment completed 11/12/09, physical exam completed 11/12/09, and annual medical assessment completed 12/16/10, physical exam completed 12/16/10; Individual #283 annual medical assessment completed 8/18/09, physical exam completed 9/1/09; and annual medical assessment completed 10/17/10, physical exam completed 9/22/10; Individual #338 annual medical assessment completed 9/21/09, physical exam completed 9/21/09, and annual medical assessment completed 10/18/10, physical exam completed 10/18/10; o Undated report, Emergency Room (ER) visits for seizure activity; o Individuals with Vagus Nerve Stimulator (VNS), undated; o List of individuals and the seizure medications/dosages prescribed, undated; o Continuing education certificates for PCPs for prior six months; o PCP new to Facility - Form 3764; o Do not resuscitate information (name, date implemented, reason), undated; o Do not resuscitate list, revised 12/3/10; o Texas Department of Health Standard Out-of-Hospital Do-Not-Resuscitate Order for Individual #209, Individual #8, Individual #276, Individual #282, Individual #378, Individual #287, Individual #195, Individual #127, Individual #250, Individual #290, Individual #126, Individual #79, Individual #278, Individual #49, Individual #205, Individual #299, Individual #181, Individual #24, Individual #179, Individual #36, Individual #122, Individual #15, Individual #64, Individual #284, Individual #247, Individual #316, Individual #2, Individual #21, Individual #160, Individual #340, and Individual #101; o Resuscitative Status II for: Individual #276, Individual #282, Individual #378, Individual #287, Individual #195, Individual #127, Individual #250, Individual #290, Individual #126, Individual #79, Individual #278, Individual #49, Individual #205, Individual #299, Individual #181, Individual #24, Individual #179, Individual #36, Individual #122, Individual #15, Individual #64, Individual #284, Individual #247, Individual #316, Individual #2, Individual #21, Individual #160, Individual # 340, and Individual #101; o List of individuals by name, residence, date of birth, age, and admission date;

	○ Colonoscopies in 2010, undated; ○ DADS Policy #009: Medical Care, dated 7/20/10, including Exhibit A – Health Care Guidelines with Appendix A: Pharmacy and Therapeutics Guidelines, Exhibit B - US Preventive Services Task Force Guidelines, Exhibit C - American Cancer Society Breast Cancer Screening policy, Exhibit D – American Cancer Society Breast Cancer Screening – MRI policy, Exhibit E – Tuberculosis – Targeted Tuberculin Screening Form, and Exhibit F – TB Questionnaire for Children; ○ The following SSLC policies: Medical Care L: • Participating in Medical Staff Meeting, draft revision 9/23/10; implementation 7/1/10; • Medical Care L2: Tracking Annual Visual Screening/Acuity Testing, draft/revision 10/8/10; • Medical Care L.3: State Center Assurances, draft/revision 11/4/10; • Medical Care L.4: Health Care Documentation, draft/revision 11/4/10; • Medical Care L.5: Hospitalization, Transfers, and Readmission, draft/revision 11/4/10; • Medical Care L.6: Management of Acute Illness and Injury, draft/revision 11/4/10; • Medical Care. L.7: Prevention, draft/revision 11/4/10; • Medical Care. L.8: Quality Assurance, draft/revision 11/4/10; • Health Care Guidelines (HCG) LL: Policy Statement; • HCG: Medical and Nursing LL.1: Documentation, draft/revision 11/4/10; • HCG: Medical and Nursing LL.2: Medical Documentation – Active Problems List, draft/revision 11/4/10; • HCG: Medical and Nursing LL.3: Documentation of Acute Medical Problems, draft/revision 11/4/10; • HCG: Medical and Nursing LL.4: Addressing Chronic Health Problems, draft/revision 11/4/10; • HCG: Medical and Nursing LL.5: PCP orders, draft/revision 11/4/10; • HCG: Integrated Progress Note Documentation LL.6: Integrated Progress Note Documentation, draft/revision 11/4/10; • HCG: Medical and Nursing LL.7: Consultations, draft/revision 11/4/10; • HCG: Medical and Nursing LL.8: Hospitalizations and Transfers and Readmissions, draft/revision 11/4/10; • HCG: Medical and Nursing LL.9: Annual Plan of Care, draft/revision 11/4/10; • HCG: Medical and Nursing LL.10: Nursing Documentation, draft/revision 11/4/10; • HCG: Medical and Nursing LL.11: Seizure Management Overview, draft/revision 11/4/10; • HCG: Medical and Nursing LL.12: Seizure Management Medical and Nursing, draft/revision 11/4/10; • HCG: Medical and Nursing LL.13: Psychotropic and Positive Behavior Support Overview, draft/revision 11/4/10, approval 11/4/10, implementation 12/5/10;

	• HCG: Medical and Nursing LL.14: Psychotropic/Positive Behavior Support Medical and Nursing, approval 11/4/10; implementation 12/5/10; • HCG: Medical and Nursing LL.15: Management of Acute Illness and Injury, draft/revision 11/4/10 • HCG: Medical and Nursing LL.16: Management of Acute Illness and Injury – Medical and Nursing Expectations, draft/revision 11/4/10); • HCG: Medical and Nursing LL.17: Prevention Overview, draft/revision 11/4/10; • HCG: Medical and Nursing LL.18: Prevention – Medical and Nursing Process Criteria, draft/revision 11/4/10; • HCG: Medical and Nursing LL.19: Nutritional Management Planning Overview, draft/revision 11/4/10; • HCG: Medical and Nursing LL.20: Nutritional Management Planning Process Criteria, draft/revision 11/4/10; • HCG: Medical and Nursing LL.21 Management of Chronic Conditions Overview, draft/revision 11/4/10; • HCG: Medical and Nursing LL.22: Management of Chronic Conditions – Medical and Nursing, draft/revision 11/4/10; • HCG: Medical and Nursing LL.24: Physical Management Overview, draft/revision 11/4/10; • HCG: Medical and Nursing LL.25: Physical Management Process Criteria, draft/revision 11/4/10; • HCG: Medical and Nursing LL.26: Pain Management Overview, draft/revision 11/4/10; • HCG: Medical and Nursing LL.27: Pain Management Process Criteria, draft/revision 11/4/10; • Integrated Clinical Services G.1.2: Epileptic and Psychotropics Management, draft 11/23/10; • Providing HealthCare Services M.24: Seizure Management, approval 11/8/10, implementation 8/1/10, 12/8/10; o Plan of Improvement/Self-Assessment, December 2010, Section L; o Request to post/training roster: medical care policies L and LL, dated 11/23/10, and 12/6/10; o QI tool Settlement Agreement Section L.l Medical care: Routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care, dated 11/10/10 (blank example), and 11/27/10, and 11/28/10 review of ten records; o Medical team meeting minutes, dated 12/6/10, 1/3/11, and 1/5/11 with Infirmary residents, hospital admissions, and campus nursing log; o List of deaths in past year; o Individuals with date of last mammogram; o Number of individuals on each physician's caseload;

	- Individuals on medications for osteoporosis;
	- List of bone density scans done in 2010;
	- Individuals admitted to emergency room between 11/1/09 and 11/16/10;
	- Avatar pneumonia tracking from 7/1/10 to 11/22/10;
	- Individuals with pneumonia/type of feeding, from 7/09 through 11/10;
	- Individuals in last year diagnosed with pneumonia;
	- Individuals in last year admitted to the hospital;
	- Infirmary admissions since November 2009;
	- Drug utilization report – antibiotics;
	- Drug Order Report Jejunostomy tube (J-tube), from 7/1/10 through 12/31/10;
	- List of individuals with feeding tubes;
	- List of medical staff;
	- Medical Department Cardiopulmonary Resuscitation (CPR) Training and completion date;
	- CCSSLC Monthly Psychiatric Services Review (PSR) minutes, dated 12/28/10;
	- "American Cancer Society Guidelines for Breast Screening with MRI as an Adjunct to Mammography," A Cancer Journal for Clinicians, 2007; 57; 75-89;
	- "American Cancer Society Guidelines for Breast Cancer Screening; Update 2003," A Cancer Journal for Clinicians, 2003; 53; 141-169;
	- Nursing Care Policy M.21: Communication with Hospitals and other Long Term Care Facilities, draft 12/13/10, approval 11/8/10, implementation 12/8/10;
	- SSLC Records Verification Checklist for Hospitalization;
	- Neurology Clinic schedule for July through December 2010;
	- Orthopedic Clinic schedule for July through December 2010;
	- All admissions from 7/12/10 through 11/16/10;
	- Transition packets (medical information) for the following individuals: Individual #27, Individual #344, Individual #121, Individual #185, Individual #66, Individual #84, and Individual #11;
	    - Mock Code Drills Committee minutes, dated 12/2/10;
	    - State of Texas Medical Emergency Response Policy #044, dated 7/21/10;
	    - Emergency Training Curriculum for Nurses, Emergency Response/Mock Code, Respiratory Oxygen set up, Nebulizer set up, Tracheotomy Care, and Suction;
	    - Emergency Equipment Checklists for each residence since August 2010;
	    - Revised Emergency Cart Checklist forms, 8/27/10;
	    - July through October 2010 Mock Code trend data;
	    - Nursing Education Department, trends of the emergency competency checks for November 2010;
	    - Actual code documentation for Individual #375; and
	    - CCSSLC's Mock Medical Emergency Drills, from July 2009 through November 2010.
	- **Interviews with**:
	    - Sandra Rodrigues, MD, Medical Director;
	    - Sharon Alexander, FNP [Family Nurse Practitioner];

	o Althea Stewart, RN, Compliance Nurse; o Colleen M. Gonzales, BSHS, Chief Nurse Executive; o Rhonda Lynn Warner, RN, QA; o Della Cross, RN, Nurse Educator; and o Kristen Middleton, RN, Nursing Education. o **Observations of**: o Individual #286, Individual #340, Individual #21, Individual #43, Individual #22, Individual #179, Individual #183, Individual #153, Individual #307, Individual #214, Individual #284, Individual #348, Individual #7, Individual #292, Individual #36, Individual #269, Individual #173, and Individual #240; and o Use of emergency equipment at Kingfish.
	Facility Self-Assessment: The Facility's POI described many of the activities that had occurred in the last six months to move toward compliance with the Settlement Agreement. This information showed that the Medical Department had begun the steps in implementing three out of the four requirements of this section. Based on the POI, however, the Medical Department realized these important steps were only the beginning of the process to eventual compliance with the Settlement Agreement, and they identified themselves as noncompliant with all of the provisions of Section L. Some of the changes the Facility highlighted in the POI, included the recruitment of two PCPs, which allows the Medical Director to pursue the many administrative duties required. The PCPs had been trained on the 27 newly created policies adapted from the Health Care Guidelines. A medical morning meeting had been created, and was well attended by the Medical, Dental, Pharmacy, and Nursing Departments, and allowed for information sharing with the goal of achieving a standardized approach to care for many areas of health. A new policy was being implemented focusing on aspiration pneumonia. There was a Registered Nurse (RN) assigned to the department with focus on medical QI. An area that the Facility recognized needed further improvement was in the development of formal quality assurance/improvement activities. A monitoring tool had been developed, and, according to the POI, 10 records had been reviewed. The results of the record reviews were not reported in the POI. The QI Department was working to establish inter-rater reliability. The POI indicated that the "QA Department will begin (12/13/10) developing an action plan to ensure monitoring of the implementation of the LL procedures." It was anticipated that by 2/1/11, a "medical quality process" would be developed and implemented. As these more formal processes for assessing compliance with the Settlement Agreement are developed, resulting data and analyses of that data should be included in the Facility's POI to supplement the valuable narrative information describing the Facility's efforts toward compliance.
	Summary of Monitor's Assessment: Since the last review, many important steps had occurred that were essential in reaching the goal of compliance. The Medical Department now had an improved complement of PCPs. This allowed the Medical Director to provide time and expertise to the many administrative duties required of the job.

	The morning medical meeting had been initiated, and represented a first step at standardizing care across the Facility, as well as allowing a team approach to be used with the PCPs. With the involvement of many departments, it should assist in developing the necessary integrated approach to the assessment of individuals, and the development and implementation of treatment plans. The morning medical meeting had the potential to be more than simply a venue for information sharing, and could become a forum for critical thinking of the cases discussed, especially with focus on preventing recurrence of an acute illness or hospitalization. As one of the outcomes of that meeting, the team should focus on identifying systemic problems and potential solutions. With skillful facilitation, this meeting could set the expectations and standard for quality of care across the Facility. Minutes of the meeting should track concerns until closure is achieved and documented. There remained a great need for clinical pathways for many illnesses common to the ID/DD population. A large body of policies had been developed and approved to provide the foundation for the standard of care at the Facility. However, CCSSLC was early in the phase of developing quality care, and it will require time for a positive impact of all these endeavors to be realized, in order for the Facility to meet the requirements of the SA. Since the last review, the Facility had implemented a number of interventions to address the emergency response systems. Some of these included: a committee that met monthly to review Mock Codes and actual codes, and implement Action Plans for any problematic issues identified; two additional staff were hired in the Competency Training Department (CTD) and were working with Nursing Education in conducting the Mock Codes; the implementation of a Mock Code Class in December 2010 that was taught by CTD staff and a Certified Pulmonary Resuscitation (CPR) instructor; the steps for CPR were added to the back of the staff's name badges for a quick reference; color coding was added to the Do Not Resuscitate (DNR) lists that were kept with the emergency equipment; the actual use of the emergency equipment during drills; the implementation of a tracking sheet indicating the date and time of the Mock Code, comments and concerns, any immediate plans of correction implemented, any system plans of correction implemented, the status of whether or not the staff pass or failed the drill; and, the implementation of spot checks for the use of the emergency equipment by the Nurse Educators. Based on these systems being implemented since the last review, the Facility had begun developing and implementing a very promising system for practicing, reviewing and analyzing emergency procedures, as well as data generated from the emergency medical drills.

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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	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, Do Not Resuscitate (DNR) Orders, and	Noncompliance

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	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.	mock drills. Additional information regarding medical care is found below in the section addressing Sections L.4 of the SA. <u>Staffing</u> Since the last Monitoring Team visit, Medical Department staffing had improved. There was an additional contract physician, and a contract physician assistant (PA). There was discussion of the contract physician becoming a State employee. This would help to ensure the stability of the position. Especially with professionals in health care, the time spent by the Medical Director and other departments orienting a new contract PCP was time taken away from other duties. Filling a State position was a sign that the department is stabilizing, which is important to the individuals and to the other staff at the Facility. Additionally, the addition of a physician assistant, under the direction of the Medical Director, allowed the Medical Director to concentrate on the administrative needs of the Medical Department. The changes in staffing allowed for changes in caseloads for the PCPs. As of 11/10, the Medical Director no longer had a direct caseload. The Medical Director supervised an FNP who had a caseload of 76 individuals, as of 12/13/10. She also supervised the PA who had a caseload of 83 individuals with medical complexities. One physician had a caseload of 64, and the other physician had a caseload of 72. This was an important advance, as it allowed the Medical Director uninterrupted time to research policies, plans, clinical pathways, and to represent the department at various administrative meetings. The Facility had been unable to recruit a full time psychiatrist. According to the CCSSLC Monthly Psychiatric Services Review (PSR) minutes of 12/28/10, there were ongoing efforts at recruitment, using both recruitment agencies as well as advertisements in selected professional journals. In addition to the Consulting Psychiatrist who regularly spent 12 hours per week at the Facility, a contract psychiatrist was expected to be on site beginning in February, for two months, to assist the department. Staffing of the Psychiatry Department is discussed in further detail with regard to Section J of the Settlement Agreement. Due to the fact that the Medical Director had many administrative duties, additional assistance had been provided. There was an Administrative Assistant for the office, a Medical Program Specialist who provided clerical support, and a Medical Compliance RN who assisted with policy development, quality assurance, training, and oversight of the SA and POI. These were essential steps in improving the capacity of the Medical Department. In addition, resources from the community were used to supplement the medical	

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		services on campus. A number of clinics were held on campus for Neurology (on 7/26/10, 8/23/10, 9/13/10, 11/27/10, and 12/8/10) and Orthopedics (on 7/21/10, and 10/20/10). Continuing education credits were reviewed for the PCPs to ensure they were up-to-date with regard to their skills and knowledge base. This review included only the State employee positions. Since the last monitoring visit, each had completed several hours of continuing medical education (CME). Of note, one staff physician completed 41 hours of continuing education. During the past two years, CPR training had occurred for all staff listed as working for the Medical Department, except for the two psychiatric assistants. The length of time of the certification was not recorded, nor the expiration date, but assuming the certification was for two years, these two employees needed recertification. There should be a system in which CPR certification is monitored to ensure all employees in the Medical Department remain current. <u>Physician Participation in Team Process</u> As of 9/23/10, medical staff meetings had been held each business day. There was a policy entitled Medical Care L.1: Participating in Medical Staff Meeting. It outlined the membership, discussion topics, and documentation process. At these daily meetings, there was a review by the hospital liaison nurse of individuals who had been hospitalized, as well as a review of Infirmary admissions. Further issues were identified through the Facility nursing log. A member of the Monitoring Team attended the medical staff meetings on three days during the week of the Team's visit. Attendance included the medical staff, as well as representatives from the Pharmacy and Dental Departments, and several representatives from the Nursing Department. The Medical Program Specialist took minutes. The Monitoring Team made several observations following these meetings. The Medical Director should take a more facilitative role and run the meeting, rather than having each participant give their report, which left the meeting somewhat disconnected. Greater facilitation is necessary to encourage discussion and critical thinking. For instance, following the brief discussion of the individuals who had been hospitalized, there would have been ample time to discuss, in one or two of the cases, how to prevent a recurrence. This was the only time of the day at which all lead clinical departments were present. However, without focused discussion, this meeting was a valuable resource that ended up being a missed opportunity. Examples of this included the following: ▪ For one individual, Individual #270, there was discussion of difficult family dynamics, and the need for a guardian, but there was little critical thinking regarding the next steps required to obtain a guardian on an urgent basis, or of informing the Facility Director of the situation. The Facility Director's role includes making decisions/providing consents when there was no guardian, so it	

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		was important for her to be aware of the current situation. Based on the Monitoring Team's discussion with her, she was not aware of the most recent information regarding this individual. Considering the family dynamics, steps should have been being taken to resolve the guardianship issue before any critical decision was needed. ▪ Individual #161 was being medically prepared for a colonoscopy. However, he received a regular food tray for the evening meal. Because the medical preparation was interrupted, the procedure needed to be rescheduled. Unfortunately, the Medical Director did not begin the process of finding out what had gone wrong to ensure this did not occur with anyone else. When the Monitoring Team raised the issue, there seemed to be no ownership regarding resolution. The Medical Director should have appointed someone to review the details of the incident and report back to the morning meeting within a week. Once the source of the problem was identified, potential approaches to improve the system should have been reviewed. At the morning meetings, the relevant departments should be expected to participate, and provide potential options for resolution of issues identified. However, the group did not identify issues that required the need for systemic improvement. The minutes should include additional information. When the Monitoring Team requested these records, scattered pages were received, as if they were independent reports. However, on several of these documents, there was no date listed to identify if and when they were part of the minutes of the morning medical meeting. Additionally, there were many issues listed, especially from the 24-hour report, but there was no documentation of any closure to the issues. There should be a brief entry or column to enter the date resolved. Issues that have not yet been not resolved should continue to be reflected on the report. Problems, to which the physician was called during the course of the previous day, also should be tracked through the log reviewed at the morning medical meeting. The Medical Director should be aware of the breadth of problems and concerns that occur 24 hours a day, especially those issues for which closure is pending. Even with these concerns, the systematic documentation of these meetings was a welcome addition to the system of information available to the Medical Director for tracking issues. Infirmary rounds included all the PCPs. There was attention to confidentiality, but the rounds included a review of information so all participants were aware of critical issues should they be called to provide coverage. The following issues, identified by the Monitoring Team during rounds, illustrated the lack of critical thinking during this process: ▪ For Individual #269, there appeared to be no probing for the reason the	

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		individual was in a deep sleep during the day. This observation had been noted for several days in the residence prior to the individual's admission to the Infirmary. When the record was researched, the dosage of Seroquel had recently been changed/reduced. Although the physician expected the order to be administered in the evening, it was sent from the pharmacy as a morning dose. It was written as once daily, and the pharmacy did not understand the context of the change. Once discovered, correction and clarification of the orders was immediate. There was also the additional concern that the pharmacy did not question the administration of a once daily dose of Seroquel in the morning. When psychotropic medication is changed, there should be a review, including the time of day administered, and the physician should be alerted to any irregularities. Given the medications sedative effects, the pharmacist should have asked the PCP the critical question of why this medicine was given in the morning rather than at bedtime. When asked what several different abbreviations meant on the Infirmary report, there was, at times, no clear answer. It is suggested that abbreviations not be used in these notes, or an abbreviation list be standardized and adhered to without exception. Additionally, the hospital liaison nurse had to handwrite and then transcribe all notes. She took handwritten notes at the hospital, and then returned to the Facility to enter them into the computer for review at the morning medical meeting. Providing a laptop would save valuable time. The expertise of this nurse could then be used to enhance the morning medical meeting by providing background information in anticipation of questions asked during review of cases. <u>Routine and Preventative Care</u> Preventive care can be measured in a number of ways. The following provides a description of the reviews conducted to determine if CCSSLC was providing individuals with adequate preventative care. Colonoscopies are recommended for those ages 50 and over as a screening tool for colon cancer. Based on the census information, there were 123 individuals age 50 and over. The Monitoring Team requested, for those individuals over age 50, the date of the last colonoscopy and the reason (preventive or evaluation of an active problem). The Facility also was asked to provide a reason if there was no date of a colonoscopy that could be found for this group. The goal was to determine the number of individuals, over age 50, that had undergone a colonoscopy in the past as a measure of ongoing preventive care. A list was provided for those who had undergone colonoscopies in 2010, which totaled 19 individuals. There was no information provided as to the reason these were completed (preventive, signs and symptoms indicating need for a work up, etc.). There was no information about those individuals who received colonoscopies in prior years. There	

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		was also no information provided regarding why individuals over age 50 had not undergone a colonoscopy. As a result, the Monitoring Team was not able to measure preventive care using colonoscopies as an indicator. Another measure of preventive care was the percentage of women over age 50 who had timely mammograms (the guidelines continue to change, and the measurement starting at age 50 avoids the controversies of mammography for women in the 40s). A list was submitted which listed 55 individuals and due dates for mammograms. Of these, 24 were overdue for a mammogram. This was a compliance rate of 31 out of 55 (56%). However, when reviewing the list, there were several individuals who were less than 50 years of age. Further, on the census list, there were approximately 58 women who were over age 50 residing at CCSSLC. This suggested the need to review the data, and obtain a list of women who are over age 50 (or over age 40 depending on the national recommendations being followed), and then determine the mammogram status of each. For many of those listed as having received mammograms in the past, 23 out of 55 (42%) had no entries under the order column indicating a date if the test had been scheduled, or were marked as "deferred." This is an area needing medical QI review. Routine care can be measured by the timeliness and quality of annual medical assessments. Assessments were submitted for twenty individuals, and the dates compared to the prior year. The list of 20 individuals, and relevant dates are included in the section above that describes the documents reviewed. This list includes the annual medical assessment and annual physical exam dates separately, because they were not always done at the same time. There are many potential dates from which one can determine if an evaluation is overdue. Due to the complexity of both the annual medical assessment and physical exam potentially having different completion dates, the due date was considered to be 365 days from the last annual medical assessment. The due date for this evaluation was calculated as 365 days from the last physical exam. Unless a reason was indicated, a physical exam was considered not to be timely if it lapsed beyond seven calendar days of the annual medical assessment. The same was chosen as an overdue date if the annual medical assessment was completed more than seven calendar days after the physical exam. Based on the above information, zero out of 19 (0%) were in compliance for medical assessments being completed within 365 days of the prior evaluation. For Individual #158, the 2010 annual medical assessment was not submitted, so no compliance determination could be made. The annual medical assessments were overdue from two to 60 days. For physical examinations, two of the 19 (11%) were in compliance with the 365-day interval. For Individual #317, the 2009 physical exam was not submitted, and	

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		was not included in the calculation. There was a range of two days to 63 days for physical examinations being overdue. There were also time intervals between the annual medical assessment and physical exam in certain reviews. These included the assessment for: Individual #9 (annual medical assessment 11/10/10, physical exam 12/30/10), Individual #103 (annual medical assessment 12/3/10, physical exam 12/6/10), Individual #212 (annual medical assessment 11/24/09, physical exam 10/28/09; annual medical assessment 12/8/10, physical exam 12/30/10), Individual #124 (annual medical assessment 11/30/10, physical exam 12/8/10), Individual #252 (annual medical assessment 12/6/10, physical exam 11/16/10), Individual #299 (annual medical assessment 12/2/10, physical exam 11/16/10), Individual #368 (annual medical assessment 8/26/10, physical exam 8/30/10), and Individual #283 (annual medical assessment 10/17/10, physical exam 9/22/10). In some instances the physical was completed before the annual medical assessment. In only one instance, for Individual #9, was a reason for the delay in physical exam documented on the form. The separation of the two parts of the annual evaluation makes it less clear as to when the next annual is due. But more importantly, there was no snapshot at one point in time with complete information concerning the individual. There was no updating of information of the annual medical assessment if the physical exam was delayed, and vice versa. If not already in existence, a policy should be developed to guide the PCPs in ensuring the two parts of this annual evaluation are completed simultaneously (with reason recorded if this does not occur), and that they are completed within a 365-day window of time. Another component of routine and preventative care is infection control. Members of the Monitoring Team met with Facility Administration, Nursing and Medical Departments to review an ongoing outbreak in a building that recently had been quarantined. Two index cases diagnosed with scabies occurred on 12/9/10, with a recurrence of scabies in one of these individuals on 12/30/10. A total of 10 individuals were diagnosed with scabies at the time of the meeting. Nine of these individuals lived in one building. One individual returned from a hospital with signs and symptoms of scabies, but no other individual in that building developed a rash or symptoms, and another building subsequently had several cases. Diagnosis was made by clinical history, typical exam findings, and sending photographs for confirmation of the diagnosis to a dermatologist. To address the issues, there had been various tasks completed, including doing laundry at a water temperature of 140 degrees. Additionally, direct support professionals in the building of the outbreak presumably were not cross covering to other buildings. Since the outbreak began, there had been two in-service trainings done on scabies, Methicillin-	

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		resistant Staphylococcus aureus (MRSA), and C difficile (c-diff). An outside company with expertise in eradication of outbreaks arrived on 1/3/10, to chemically treat the environment (walls, etc.). Individuals were moved to other areas of the building to avoid exposure to the chemicals. Facility Administration had a copy of the chemical data sheets for chemicals being used. Concerns related to the Facility's management of this outbreak included: ▪ It was reported that in no case was a diagnosis confirmed by microscopic slide review of a scraping. Considering the intensity of time in cleaning and reviewing cases, as well as the cost of hiring an outside firm to spray chemicals in the building and the disruption to the lives of the individuals, there should have been verification of at least one skin scraping to confirm the diagnosis. Additionally, the local public health department might have been a valuable resource to provide experience and practical expertise in resolving scabies outbreaks in large group settings (e.g., nursing homes, schools, etc.). ▪ Once the outbreak was identified, there was not a timeline or log created with details of individuals with rash development, date medication was prescribed, and time medication was administered. A time log was developed at the suggestion of one of the Monitoring Team members. Such a log would be a valuable tool for anyone attempting to investigate the outbreak. ▪ The hospital should have been, but was not notified, that a discharged individual developed scabies shortly after discharge. This would have been important to allow the hospital to review the case internally, particularly if there were other complaints made to the hospital regarding the same problem. ▪ The spraying of chemicals might induce contact chemical dermatitis, which might confuse the ongoing evaluation of the outbreak. In addition, such chemicals might induce respiratory issues if chemicals were aerosolized. ▪ In this case, hiring a chemical cleaning company to spray the environment might theoretically remove certain bacterial infections from the environment, but it was not clear what impact such chemical treatment would have on eradication of scabies. Other steps that should have been taken, such as bagging clothes and shoes, were not initiated until the week of the Monitoring Team's review. ▪ There should have been a baseline head-to-toe assessment of all individuals living in that building, and probably throughout the Facility (or at least the residence) looking for any similar rash, because spreading from one building to another remained a concern. ▪ Employee health policy and procedure should have been reviewed to ensure there were no barriers to employees with signs or symptoms obtaining rapid medical evaluation and treatment. At the time of the review, the Monitoring Team was informed that two staff had been treated for scabies. ▪ It was learned that individuals had bought donated clothing, and there also	

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		might have been times that individuals had worn newly bought clothing without it being laundered first. A policy/procedure should be developed to ensure all clothing, new to the individual, is washed before it is worn. ▪ It also was learned that, although direct support professionals were not covering other homes, other staff were not limiting their contact to only individuals in the quarantined building. For example, nursing, medical, and habilitation therapies staff were not following proper quarantine procedures until the Monitoring Team raised this issue. This outbreak was an opportunity to review the policy concerning isolation and quarantine to ensure it was up-to-date, and accurate concerning the type of outbreak. It also was an opportunity to ensure staff were trained on the Facility quarantine protocol, with attention to rules of quarantine and how it applied to visitors, family, vendors, etc., including the communication system with such people. Each department should have ensured their employees were not cross covering other buildings, inclusive of such departments as maintenance, housekeeping, and nursing. ▪ Until the Monitoring Team was on-site, the outbreak had not been reported to the State Office. Again, reporting to the State Office would have facilitated additional support and guidance. ▪ Overall, the Medical Department demonstrated a lack of leadership with this situation, and there was little evidence of a structure in place for tapping into expertise for outbreaks in a timely manner. This incident demonstrated that the Facility lacked a system to effectively and efficiently handle outbreaks. Moreover, in reviewing documents after the on-site review, additional concerns were noted. Initially, a small scrap of paper was submitted listing the names of 10 individuals treated for scabies, along with the date of diagnosis. Later, a copy of the time log for the outbreak of scabies was submitted, entitled "rash 12/8/10." On review of Individual #270's record for an unrelated problem, there was a dermatology consultation from 12/7/10 in which the dermatologist stated: "generalized popular eruption, is suggestive of a widespread scabies. I will use Elimite….". This individual was not listed in the time log, which suggested scabies had been at the Facility earlier than the timeline suggested. If this individual was from another building, then the outbreak was not confined to one building. It is not known if the Medical or Nursing Departments, or Facility Administration was aware of this case of scabies from 12/7/10. There should have been prompt steps taken to isolate this case, and begin environmental treatment by washing and bagging clothing, etc. The Facility should view this incident as an opportunity to learn and develop a system that can respond to such situations. There should be prompt documentation of all action steps taken until the eradication of the outbreak, and then a final meeting should be held inclusive of all involved departments. The group should discuss the event, how to	

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		prevent a recurrence, how to act more promptly, how to improve communication, how things should be accomplished differently for a future event, etc. It would be helpful to use the format for a root cause analysis to conduct such a review, and develop a plan to correct identified deficiencies. At a minimum, the Medical Director should create a network of resources that are always available to provide guidance for any type of outbreak. This should include development of a roster of web sites and professionals with expertise in outbreaks in congregate settings. Additionally, there should be policies developed that cover topics such as scabies, head lice, etc. Staff should be trained so they are familiar with the initial and ongoing steps necessary to stop an outbreak. Records on those who had died in the six months prior to the monitoring team visit were reviewed to determine events surrounding the death. The focus of the review was on quality of care, but also maintenance, preventive, and emergency aspects of care. The following summarizes the findings for each individual: ▪ Individual #180 was identified as being at high risk for aspiration pneumonia. She had a diagnosis of dysphagia, GERD, seizure disorder, and was fed by a G-tube (placed 1993). The annual medical summary, dated 2/28/10, indicated that on 2/1/10, her feeding formula was changed, and the volume was increased. She had been taking Jevity 1.5 190 milliliters (mls) QID and the formula was changed to Glucerna 1.0 275 ml QID. A 2/17/10 nutritional evaluation recommended that an order for an additional six ounces of fluids BID be discontinued as this extra daily fluid exceeded daily fluid requirements. This latter recommendation was not followed, however, and she continued to have the extra fluid. Her treatment record indicated that she was to get six ounces of fluid at 1500 hours, and 150 ml of water at 1600 hours, and a bolus of feeding at 1700 hours. She was hospitalized for pneumonia on 2/26/10, a few weeks after the bolus feeding volume had been increased. On 3/21/10, she was again hospitalized. The discharge summary documented that: “she was found to have shortness of breath, fever, and cough on the day of admission.” She was discharged on 3/26/10. Again on 3/31/10, she was admitted to the hospital, for “shortness of breath, fever… found yesterday… chest x-ray showed pneumonia.” On August 26, 2010, she developed intermittent fever, the source of which remained elusive. On 9/14/10, she was admitted to the hospital for fever and pneumonia. She was discharged on 9/22/10. She then did well until 11/20/10. At 1730 hours, the direct support professional stated that: “patient yelled out and there’s something wrong and she’s changing colors… cool to touch, skin color pale… her face flushed deep red then faded to pale white again…” This occurred while she	

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		was in a hallway in the wheelchair. Staff obtained the crash cart, as a direct support professional and nurse moved her to her room, and placed her in bed with a backboard. Oxygen (O2) was started, as well as CPR. Emergency Medical Staff (EMS) arrived, and took her to the hospital. There was "no obvious cause of death," and she was referred to the medical examiner. An autopsy was completed, but no final report was available. The preliminary verbal report indicated she died of a pulmonary embolism. In reviewing the record, there were several concerns, unrelated to the suspected cause of death, which could be used to teach the IDT and the medical team. Although G-tubes are used to decrease aspiration, they do not treat GERD, and might make GERD worse. She had several hospitalizations for pneumonia, and in two of the histories on admission to the hospital, the onset of illness was considered abrupt. This could be consistent with aspiration pneumonia due to reflux. It also might indicate that direct support professionals were not trained to notice and record early signs of health status change. Additionally problematic, her feeding was increased in volume and she was given bolus, both of which might aggravate GERD. Continuous feeding at a slower rate might have assisted in minimizing GERD. Finally, her fluid was not reduced as recommended by the nutritionist. She was on a tight schedule of fluid through her tube, fluids being ordered at 1500 hours, 1600 hours, and 1700 hours. When checking the treatment record for the day of her death, there was no entry for any of these three hours. This might indicate the nurse was behind on administering medication, or gave the medicine, but with the code, was distracted by the emergency and did not get back to complete the record. If the individual was late in getting the fluids, she might have gotten the fluids with little time between administrations. This might have aggravated GERD. The time of administration of bolus feedings, water supplements, and flushes need to be reviewed for individuals with GERD, and the schedule of administration altered, as appropriate, so that adequate time is given between bolus and fluids. A separate issue was the need for continued training and retraining on CPR. Valuable time might have been lost as the staff moved the individual to her room and placed her on a bed board on her bed. Documentation was not provided explaining why this was done, as opposed to placing her on the floor and starting CPR. According to a verbal report, the cause of death was a pulmonary embolism. Of interest, there was no Deep Vein Thrombosis (DVT) found in Doppler evaluation of both lower extremities, suggesting the source of the emboli was elsewhere. This was an unexpected and apparently unpreventable event.	

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		▪ Individual #188 had a history of Percutaneous Endoscopic Gastrostomy (PEG) insertion for dysphagia and silent aspiration, a history of pica with latex glove ingestion (5/18/09), giant hiatal hernia, GERD, hypothermia, and bradycardia. He had a prior cardiac arrest on 10/21/01 presumed associated with Geodon use. His last cardiac consultation, in which his bradycardia was reviewed, was on 6/3/10. He had a number of pneumonias and bronchopneumonias in the past, including on 10/25/06, 4/30/07, 2/25/09, 1/11/10, and 4/1/10. A chest x-ray, on 6/17/10, indicated no acute cardiopulmonary process. On 6/21/10, he was found unresponsive on the floor in his room, without vital signs. CPR was begun and EMS arrived and took over emergency care. He did not survive the code. The autopsy indicated cause of death as bilateral bronchopneumonia. According to documentation, there had been no signs or symptoms of acute illness prior to his death, with the exception that the administrative death review summary and recommendations of 11/23/10 referred to information that he had a temperature of 103 degrees at the time of the code, although the source of the information was not provided. It remained troublesome that the autopsy report indicated bronchopneumonia, when the record did not reflect any acute illness. It is potentially problematic that a series of direct support professionals, over several shifts, as well as nurses over several shifts, would have missed early health status changes. The frequency of in-service education training on health status change might need to be reviewed if these same staff also cared for other individuals who "suddenly" became ill and were sent to the ER or hospitalized in the past year. Given he had a feeding tube and a history of pica, the record was unclear as to why he was found on the floor, and suggested a gap in supervision. This could have been due either to the team not creating a plan of adequate supervision to meet his needs, or in implementation of the plan. Based on the information provided, it was difficult to clinically correlate the record documentation with the autopsy findings. He had significant other clinical illness, such as his bradycardia, which would not be identified on an autopsy, yet might have been a contributing comorbidity leading to his death. From the information provided, the medical staff did all that was reasonably expected for his acute demise. In reviewing his treatment overall, again, a number of lessons could be learned.	

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		It was noted that he also had GERD associated with a large hiatal hernia and was on a proton pump inhibitor. The cause of pneumonia (aspiration or community acquired) is difficult to separate, but given his GERD, he would have been at increased risk for reflux and aspiration. It is recommended that there be a more aggressive approach to individuals with diagnosed GERD, with consideration of evaluation and treatments based on findings [Esophagogaastroduodenoscopies (EGDs), surgical options, etc.), to prevent reflux and aspiration as a contributing cause for pneumonia. If GERD contributed to one or more of the pneumonias, treating GERD would also increase the quality of life of the individual. ▪ Individual #152 was a Hepatitis B carrier, also with dysphagia and a G-tube. He had been on Adefovir treatment for the Hepatitis B carrier status, but developed hepatocellular carcinoma with rapid progression. He was placed on hospice for end of life palliative care. This death was predictable, but unavoidable based on the information provided. ▪ Individual #75 had a diagnosis of attention deficit and impulsive type hyperactivity disorder, also with Hepatitis B carrier status, dysphagia, bilateral blindness, and moderate aortic insufficiency. He collapsed on the floor and coded. The autopsy showed an acute dissection of the ascending aorta with normal cardiac valve leaflets. Given the information provided, this death was unpredictable, and unavoidable. ▪ Individual #320 had chronic renal failure, congenital short esophagus, and "massive GI reflux." He had a history of recurrent vomiting and recurrent pneumonia. He had a Barrett's esophagus. A G-tube was placed in 3/10. He was hospitalized on 6/30/10 for pneumonia and a urinary tract infection (UTI), and he was admitted for prolonged antibiotic therapy at a skilled nursing facility (SNF) on 7/22/10. On 9/15/10, he again developed fever, pneumonia, and a UTI. Despite enteral nutrition and close monitoring by the dietitian, his weight declined from 124 pounds in November 2009 to 99.4 pounds in October 2010. He was admitted to the Infirmary six times in 2010 due to the events listed above. His terminal acute illness was brief, in which he had projectile vomiting and developed acute respiratory distress with failure. A preliminary autopsy report indicated he died from bronchopneumonia and gastritis. In reviewing his record, although there was an aggressive approach to his dysphagia, there was less focus on the contribution of his severe GERD to the recurrent pneumonias, made worse by a congenital short esophagus. He was on Prevacid and Carafate, suggesting maximal medical treatment, but further interventions might have helped reduce his severe GERD. A J-tube or	

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		consideration of a fundoplication, if surgically feasible in this individual with anatomic anomalies, or laryngeal tracheal separation/tracheal esophageal diversion, or other surgical treatment might have reduced some of the vomiting and aspiration pneumonias, as well as treated the Barrett's esophagus. The information reviewed did not indicate a reason that additional treatment of his severe GERD was not considered beyond medication. A clinical pathway for GERD, focusing on some of these complications would have helped guide his treatment. Three of the five individuals who died in the six months prior to this review were in their 40s. Trending of data by age of death, along with other demographics, will assist the Facility in making comparisons to other state facilities, and mortality data from other states. <u>Medical Management of Acute and Chronic Conditions</u> From July 1, 2010 through November 22, 2010, there were 35 pneumonias in 31 individuals. Twenty-three of these 35 individuals had required tube placement in the past, and 12 were on oral intake. Pneumonias and respiratory illness continued to be the cause of numerous Infirmary admissions, ER visits, and hospitalizations. In July 2010, there were 16 Infirmary admissions, 10 of which had pneumonia and other respiratory illness as the reason for admission. In August 2010, there were 31 admissions to the Infirmary, for which five had pneumonia and other respiratory illness. In September 2010, there were 25 admissions to the Infirmary, of which six had pneumonia and other respiratory illness. In October 2010, there were 28 admissions to the Infirmary, of which 11 had pneumonia and other respiratory illness. In November 2010, there were 18 admissions to the Infirmary, of which eight were from pneumonia and other respiratory illness. In December, there were 32 admissions to the Infirmary, of which seven had pneumonia and other respiratory illness. Not all admissions to the Infirmary for pneumonia required subsequent hospitalization or were individuals returning from the hospital. Some were treated successfully in the Infirmary. Additionally, not all Infirmary admissions were for acute problems. Some were for planned post operatives care from Total Intravenous Anesthesia (TIVA), etc. Hospitalization rates and causes also were reviewed. In July 2010, there were 10 hospital admissions, of which six were due to pneumonia and other respiratory illness (60%). In August 2010, there were 13 hospital admissions, of which four were due to pneumonia and other respiratory illness (31%). In September 2010, there were 11 hospital admissions, of which seven were due to pneumonia and other respiratory illness (64%). In October 2010, there were 16 admissions to the hospital, of which nine were	

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		due to pneumonia and other respiratory illness (56%). In summary, for any month reviewed, between 31% and 64% of all acute care admissions were due to pneumonia and other pulmonary problems. This requires urgent review and attention, and the aspiration pneumonia risk policy and protocol was timely in endeavoring to reduce the incidence of pneumonias. Due to the fact that several of the individuals who died had histories of aspiration pneumonia, and that the majority of deaths reviewed at the Monitoring Team's prior visit were due to aspiration pneumonia, several individuals who had been hospitalized for pneumonia were reviewed. The following provides a summary of these reviews, including positive examples of appropriate management of individual's conditions, as well as concerns related to treatment: ▪ Individual #311 had a diagnosis of dysphagia and GERD. He had a G-tube placed in October 2007. On 10/9/09, he was hospitalized for pneumonia. On 5/22/10, it was documented that he had emesis "which looked similar in color to Jevity which is provided via g tube feeding. [Individual #311] had his last g tube feeding about 30 minutes ago." He was observed, but had no further emesis and no respiratory problems were noted. On 10/1/10, there was a nursing note indicating he was not acting himself, "not 'fighting anymore' as he usually does." He had a temperature of 97.7 degrees axillary with no signs or symptoms of respiratory distress. There were no further nursing entries until 10/4/10, at which time there was only documentation of a skin treatment. Then suddenly, on 10/5/10 at 2030 hours, he was noted to be coughing, with coarse rales and respiratory distress, and sent by EMS to the hospital. He was admitted to the hospital on 10/6/10 for respiratory distress, at which time he was found to have a left lung pneumonia, pneumothorax, and empyema. Once stabilized, on 10/14/10, he was transferred to a specialty hospital for additional treatment for a loculated effusion and pneumonia. He returned to the Infirmary on 11/9/10. He finally returned home on 11/15/10. On 12/7/10, he completed a chest Computed Tomography (CT) scan that indicated a complex left sided pleural fluid collection with locules of air, and abnormal pleural thickening of the pleural surfaces. Later that day at 1350 hours, a nursing note indicated he was agitated and combative, but there was no report of health instability. Then at 1410 hours, the staff reported he was having difficulty breathing, his O2 saturation was 86%, and he was sent to the ER. In the ER, he was prescribed antibiotics and returned to the Facility, and subsequently followed for conservative management by a pulmonologist. It was noted that his orders for feeding included Jevity 365 ml at 400 ml/hour, three times daily. He also received 80 cubic centimeters (cc) water before and after each bolus feeding, and 275 cc with each medication pass four times daily.	

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		He was taking a proton pump inhibitor for his GERD. The head of the bed was to be elevated at 45 degrees at all times. He was to be upright at 90 degrees during feeding and one hour post feeding. With a history of GERD, documentation of feeding formula being vomited, recurrent pneumonias during the past year, more recently complicated by an empyema and residual pleural effusion and wall thickening, he was at high risk for aspiration of reflux or emesis as a contributing factor to his repeated pneumonias. He might benefit from further, aggressive evaluation to determine if treatment of GERD, especially surgical options, would be appropriate. Additionally, the orders included precise positioning, and ensuring the orders were followed would require close monitoring around the clock. Additionally, given his GERD, bolus feedings, with additional boluses of water, have the potential to aggravate the GERD. It was not clear if consideration had been given to making his feedings continuous or intermittent rather than bolus. ▪ Individual #316 had a history of esophageal reflux, restrictive lung disease, and had a G-tube inserted 9/03. He had previously undergone a fundoplication, vagotomy, and pyloroplasty. His nursing health care plan indicated he tolerated "his feedings well with no coughing or change in respiratory status." It was noted that: "his head and shoulders must be elevated at all times and is never allowed to be flat." He received supplemental oxygen and used Continuous Positive Airway Pressure (CPAP) while asleep. He was hospitalized for pneumonia in 9/09 and later on 3/18/10. There was only one nursing note on 3/18/10 at 0940 hours that described his worsening respiratory condition. The immediate prior notes of 3/1/10 and 3/11/10 did not indicate a respiratory concern. His psychological evaluation indicated that he put his hand in his mouth causing regurgitation and increasing the risk of aspiration pneumonia. He was treated both medically with Xanax for this, as well as with a Behavior Support Plan. Additionally, he was ordered a Chlorhexidine dental treatment to his teeth, gums, and tongue as preventive treatment of aspiration pneumonia. His tube-feeding rate was at 60 ml/hour for 170 ml of formula four times daily. This individual might benefit from further evaluation with regard to treatment options of his GERD, such as a J-tube placement or other surgical options should there be an increase in frequency of his pneumonias. Additionally, positioning was essential to his care, and staff should provide continuous close monitoring to ensure appropriate positioning. For such high-risk individuals, consideration should be given to nursing assessment every shift, as this might uncover early changes in health status. The support of the Psychology Department, Psychiatry	

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		Department, and Dental Department indicated there was adequate integration of these clinical services and care. ▪ Individual #270 had both a tracheostomy (since 11/98) and gastrostomy tube. He had a history of aspiration pneumonia and GERD. He was hospitalized several times for pneumonia (4/09 to 5/09, 5/27/10 with return to the Facility on 6/25/10, 7/26/10 with bronchoscopy 7/28/10, and discharged to the Facility on 8/8/10, 10/1/10 with transfer to specialty hospital for continued treatment on 10/12/10 and return to the Facility on 11/5/10, and most recently hospitalized 12/31/10 with continued hospitalization at the time of the Monitoring Team's visit.) His GERD was treated with a proton pump inhibitor. The annual medical assessment, dated 12/9/09, indicated: "GERD: stable on Prevacid and has not had any problems in the past year." He had a history of atelectasis treated with several nebulizer treatments (Albuterol, Atrovent, and Pulmocort/Xopenex). He received Jevity 1.0 300 ml at 250 ml/hour four times daily. He also received 300 ml of water four times daily. After his return to the Facility on 11/5/10, his formula was changed to Jevity 2 Cal HN 225 ml at 150ml/hour four times daily, and water was decreased to 260 ml four times daily. Additionally, to help prevent aspiration pneumonia, the dental technicians applied Chlorhexidine mouthwash. The nursing intervention plan indicated that the direct support professional was "to ensure that head and shoulders are elevated at all times and is never to be flat, to reposition q 2 hours to best facilitate chest expansion, LVN/respiratory therapist to suction trach, using sterile technique q 2-4 hours or as needed, LVN/respiratory therapist to provide humidified air as ordered." Of concern, for the most recent admission to the hospital on 12/31/10, there were only campus RN notes at 0425 hours and 0435 hours on 12/31/10 indicating respiratory distress. There were no notes for the day prior. The next most recent note was on 12/28/10 at 1445 hours, and did not include any discussion of respiratory status. Given the complex medical conditions presented by many individuals, it would be important to develop a policy in which nurses documented every shift or every day on high-risk individuals/those frequently hospitalized. If there were any subtle signs or symptoms of health status change on 12/29 or 12/30/10, they were not recognized and recorded until he was found on 12/31/10 with respirations at 36 per minute and pulse of 135 to 140. There was no consideration that GERD might have contributed to one or more of the pneumonias. It was not clear why further medical and surgical interventions	

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		were not considered for GERD, because the reduction of pneumonias would improve both health and quality of life. ▪ Individual #239 had a history of dysphagia and GERD (confirmed on an UGI series 1985). He had several procedures done over time, including a G-tube placement (1988), fundoplication, vagotomy, pyloroplasty, tracheostomy, and a laryngectomy (1996) with diversion tracheostomy. He developed a viral pneumonia on 12/2/09, and aspiration pneumonia on 12/10/09. Records did not indicate any pneumonia in 2010. He had significant pulmonary complications from recurrent pneumonias in the past, including pleural fibrosis requiring decortication. He continued to have copious tracheostomy secretions. He has been on Prevacid and Reglan for GERD, Singulair for his reactive airway disease, and nebulizer treatments of Xopenex and Pulmicort for bronchiectasis. He used a humidifier connected to his tracheostomy. There was no information as to whether a J-tube was considered as an option in treating his GERD, as this would have provided a less aggressive next step approach to his severe GERD. A clinical pathway that listed the options would assist in ensuring each procedure is considered, from least invasive to most invasive. Additionally, the tracheal diversion usually indicates a complete separation of the esophagus from the trachea, which no longer allows oral or esophageal contents to enter the trachea. However, based on the notes written by staff, there appeared to be a lack of understanding of his surgery, and his present condition. For instance, on 8/21/10, the individual was found flat in bed, and the nurse attempted to aspirate from the G-tube to compare with fluid coming from the tracheostomy. Unless there was a suspected fistula, or the interpretation of the submitted documents was erroneous, this should not have been necessary. On 7/6/10, the nursing note indicated that the Dental Department insisted that anyone with a G-tube should not use toothpaste. This would generally be correct, but with a tracheal esophageal separation/diversion, this should not be a problem. Further in the nursing summary, it was indicated that he received Chlorhexidine oral rinse to prevent aspiration pneumonia (it is still an excellent treatment to improve oral hygiene). Again, this should not be a problem with a complete separation of the trachea from the esophagus. Staff attending to the needs of this individual should be provided training on the purpose of his tracheal separation, and an update on such issues as tooth brushing, and lack of aspiration from feeding through a G-tube. However, it would appear that this GERD was so severe, that to prevent further permanent	

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		pulmonary sequelae, a tracheal diversion was an appropriate and timely response to his serious illness. He has benefited from no pneumonias noted in 2010. ▪ Individual #173 had dysphagia, GERD, history of aspiration pneumonia and bronchopneumonia (5/30/09, 8/17/09, 11/09, and 1/2/10), and G-tube (2004) converted to a J-tube (1/15/10). He was prescribed Prevacid, Reglan, Xopenex and Pulmicort nebulizer treatments, as well as Chlorhexidine dental treatments. His Jevity feedings were continuous until the daily feeding was completed. He also received water supplements at 250 ml QID at medication pass, and 30 ml water flushes. He was to have his head and shoulders elevated at all times. He had not had any further pneumonia since 1/10, suggesting the J-tube was effective at decreasing the frequency of pneumonias. However, it was noted that his J-tube was clogged on 2/26/10, 6/8/10, 7/1/10, 8/1/10, 8/11/10, and 10/9/10. Additionally, the J-tube balloon deflated and the tube fell out on 4/22/10. These required transport to the hospital for reinsertion of the J-tube. It would be appropriate to have some further in-service training, especially to those providing medication and fluids through the J-tube, and to have increased observation and demonstration to ensure staff's understanding of the procedures. At intervals, he also had emesis, described as coffee ground in color. This suggested continued problems of GERD/esophagitis (5/10/10, 11/16/10), and there was emesis with formula on 9/3/10. These suggested the need to continually monitor for worsening GERD with frequent communication with the GI specialist. With the decrease in the rate of aspiration pneumonias, the J-tube placement had been successful in improving this individual's health. Of unrelated concern, on 12/16/10, he was found to have ant bites on his hand. This was associated with finding ants on his CPAP mask and on another individual's bed in same room. As this individual was unable to communicate and defend himself against ant bites, staff should be vigilant about observing for biting insects in the home. The Facility is urged to find ways to prevent such occurrences. The room was "treated," but given this history, it is recommended that the treatment be scheduled routinely to prevent this from occurring. ▪ Individual #58 had recurrent pneumonias (7/08, 8/08, 7/09, 3/9/10 to 4/6/10, 4/14/10 to 4/29/10, 7/6/10 to 7/26/10, and 9/25/10 to 10/20/10), as well as dysphagia, with G-tube placement (4/1/10). He pulled out his G-tube on 6/29/10. He was followed by the PNMT, and vital stem therapy was begun on 10/21/10. A subsequent Modified Barium Swallow Study was completed on 11/29/10, and he was recommended for nutrition by mouth (ground moist texture food with honey-thick liquids).	

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		His GERD was treated with a proton pump inhibitor as well as Reglan. He was ordered Pulmicort and Xopenex nebulizer treatments for his reactive airway disease. He was provided a special feeding formula to assist in addressing his pulmonary disease (Pulmicare 300 ml at 115 ml/hour four times daily, water 270 ml with medication pass four times daily). He received Chlorhexidine dental treatments to assist in preventing aspiration. With his continued pneumonias, despite a G-tube as treatment for dysphagia, as well as the intermittent/bolus schedule of formula and water, there was mention of GERD, but no further work up to determine the contribution of GERD to his recurrent pneumonias. Distention of the stomach with formula and water via a G-tube could aggravate GERD and lead to further pneumonias. A GERD evaluation would be indicated, but had not been completed. If GERD was present despite medical therapy, consideration should have been given to surgical procedures to resolve the problem, but there was no clinical pathway to set forth the expectations and options with regard to possible next steps. The reintroduction of a therapeutic diet by mouth, with close follow up by the PNMT indicated interdepartmental cooperation. His dysphagia appeared to be appropriately treated, but the GERD required further work-up. Quality seizure management is essential to quality and longevity of life. In the six months prior to the Monitoring Team's visit, there were three individuals who required ER treatment related to seizures. One individual, Individual #375, required two ER visits on 11/16/10 and 12/15/10. All were subsequently admitted to the hospital. A list was submitted which included 164 individuals at CCSSLC with a seizure diagnosis. That three out of 164 (1.8%) required hospitalization for prolonged seizures and complications of seizures suggested good control. Records for five individuals were requested to review seizure management. The following summarizes the results of these reviews: ▪ Individual #333 had a VNS, which the neurologist adjusted on 9/13/10. The neurologist recorded five seizures for September, and 99 for the year. The seizures lasted 45 seconds to one minute, with the longest being one minute and 40 seconds. He remained alert and interactive. He was also on three antiepileptic medications. He was to follow up with neurology in four months. The nursing quarterly assessment, dated 7/31/10, documented 36 seizures in the quarter and the VNS was used 14 times. Submitted seizure records were reviewed and were complete. The accumulative yearly seizure record was completed through September 2010, and seizure disorder flow sheet was completed through October 2010.	

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		▪ On 8/23/10, the neurologist saw Individual #70. He had a history of 32 seizures in 2008, and 38 in 2009, and had 14 as of the visit in 2010. The longest seizure was four minutes and the shortest was five seconds. He had a VNS and was on three antiepileptic medications. Because of side effects (thrombocytopenia), it was recommended that he be slowly weaned off Depakote and slowly introduced to Vimpat. He was to be seen in three months. The accumulative yearly seizure record was completed through October 2010, and the seizure disorders flow sheet was completed for October 2010. Submitted seizure records appeared complete. ▪ Individual #68 was prescribed three medications for seizures. She also had a VNS. The neurologist saw her on 8/23/10, at which time the VNS output was adjusted. She had 15 seizures in 2008, nine in 2009, and 26 in 2010, lasting between three seconds and four minutes. She had no signs of anticonvulsant toxicity. She was to follow up in six months. The accumulative yearly seizure record was completed through August 2010, and the seizure disorder flow sheet was completed through September 2010. ▪ Individual #24 had a progressive seizure disorder due to tuberous sclerosis. According to submitted information, the neurologist last saw him on 6/28/10 (previously seen 2/8/10 and 3/8/10 for VNS adjustment). At that time, his VNS was adjusted. He was on three medications to control seizures, but his seizures were associated with prolonged thrashing and the etiology of this activity was not clear. The individual did not tolerate a video Electroencephalogram (EEG). According to the accumulative yearly seizure record, he had four seizures in August 2010, nine in September 2010, and six in October 2010, the last month for which it was completed. The seizure disorder flow sheet was also completed through October 2010. ▪ Individual #136 had a VNS and was prescribed four medications for seizure control. The neurologist last saw him on 8/23/10, at which time his VNS was adjusted. The neurology note indicated that his last seizure at that time was in May 2010. He was to follow up in four months. The accumulative yearly seizure record was completed in June for a clustering of seizures, otherwise the year had no entries. Other years had a "0" recorded when there was no seizure in that month. Seizure management in the cases reviewed appeared timely and aggressive. The use of several anticonvulsants, as well as the VNS appeared justified. There was routine follow along by the neurologist. The accumulative yearly seizure record and seizure disorder flow sheets were completed through September and October. It is recommended that the various seizure flow sheets/records be updated each month for the prior month. There was also attention to side effects. In one case, a medication was replaced with a different anticonvulsant due to side effects.	

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		The contents of the information packet sent with an individual to the emergency room should provide the essential background information for the medical team providing care at the hospital. It is also essential to confirm that the hospital has received this information. A policy entitled Nursing Care M.21: Communication with Hospitals and other LTCF (draft revision 12/13/10, approval 11/8/10, implementation 12/8/10) was revised to include a listing of the information sent to the emergency rooms and hospitals. This was completed on 10/30/10, and included a Records verification checklist for hospitalization. This verification sheet listed the name and title of the person to whom the report was given at the hospital. This was assumed to be the person contacted by telephone. To provide proof that the packet was sent, it is recommended that the person receiving the information (e.g., EMS, hospital personnel, etc.) sign and date (with time) the sheet as verification that it has been forwarded. For instances in which the packet is misplaced, this provides initial proof for the Facility that it was sent, as well as a contact person who can provide further information such as to whom the packet was given or where it was placed. The content of the transition packet for medical information was reviewed for a number of individuals (Individual #27, Individual #344, Individual #121, Individual 185, Individual #66, Individual #84, and Individual #11). It was interesting to note that the contents were different for each individual. A standardized approach would be helpful. The date of the transition was not always clear, because the transition date listed in some documents preceded the date of the forms reviewed. These forms should focus on information that will guide the community medical team in following up on health care, and ensuring there is no confusion about current or future needs. Providing too much information, or information presented in a manner that is not user-friendly might not be effective, because staff have little time to sift through endless paper work. With this in mind, it was excellent that the volume of information was generally kept to a minimum. There were a few excellent documents that should be considered for every packet, including: current medications updated, current lab/diet/and treatments, a discharge medical assessment by the PCP, the last annual medical assessment and annual physical exam, a copy of the most recent lab and x-rays, a dental discharge summary, the most recent nutritional evaluation, and a discharge summary nursing assessment with complete vaccination list. Remote/older information, if relevant, should be typed on one of these documents as applicable (the annual medical assessment or annual nursing assessment). Handwritten entries should be minimized. It is also important to ensure that information regarding medications taken that day, and the medications that need to be provided through the transition day is provided. A copy of the current MAR would be instructive to ensure that no medication dose is missed. A list of actions pending (when the next eye appointment is due, the next lab test (specific	

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		test listed) due, etc., would also be helpful to ensure lab orders and referrals are not missed at the initial physician appointment. Additionally, this documentation should include the telephone number and name of a contact person at CCSSLC that the receiving medical office can call for additional information or clarification of information. It should be a specific person or designee assigned ahead of time who will have ready access to the individual's record. Additionally, the PCP should attend transition meetings for individuals with complex health issues, especially meetings specifically addressing transfer of health information. The PCP will begin to understand the health care system to which the individual is moving, and can answer specific questions and provide additional information in the dictated discharge assessment. Currently, the PCP/Medical Director attended at least some of the transition meetings. <u>Do Not Resuscitate Orders</u> At the time of the review, there were 31 individuals with DNR status. Some had had the DNR status since 2004. A DNR status that continues for this length of time should be reviewed periodically to determine if the individual still meets criteria for this decision. The most frequent reasons given for DNR status were osteoporosis, family request, neurological degeneration, and decline in respiratory function. These DNR decisions should be reviewed by the PSTs to ensure they are in alignment with State Office guidance. For those with resuscitative Status II, the requirement was for annual review. If annual review was not completed, then the resuscitation status reverted to Status I. From the submitted forms, 24 were up-to-date with current signatures from 2010. Five individuals had outdated signatures (dating from an earlier year), including the following individuals: (the individual is followed by the last year the Status II document was signed) Individual #205 - 2007, Individual #287 - 2007, Individual #378 - 2007, Individual #282 - 2006, and Individual #276 - 2006. No information was submitted for two individuals (Individual #8, and Individual #209). These seven individuals should be reviewed to ensure the documentation for DNR status is current or the DNR order is rescinded. <u>Mock Drills</u> Since the last review, the Nursing Department had taken some positive steps forward in its efforts to address issues regarding emergency response. The Facility had implemented a committee that met monthly to discuss, and review Mock Codes and actual codes, and to implement Action Plans for any problematic issues identified. The committee was initiated in December 2010 and conducted their first meeting on 12/2/10. The committee designated core team members consisting of representatives from the Competency Training Department, Respiratory Therapy, Nursing Education, Medical Department, a CPR Instructor, the System Data Analyst, as well as the Nurse	

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		Operations Officer, QE Director, and the Chief Nurse Executive. However, there was no representative from the Medical Department at the initial meeting. Although this was only the initial meeting, it is imperative that the Medical Department be involved in the review and analysis of the Facility's emergency response systems. From review of the minutes of the initial Mock Code Drills Committee, issues discussed included the guidelines for the committee meetings; the role of the nurses in the mock codes; location and placement of Automated External Defibrillators (AEDs); and the restructuring of mock code teams to include Nursing Education, the Infirmary Nurse Manager, and a CRP Instructor. In addition, the minutes included an analysis of Mock Codes issues including the following: ▪ Staff not responding seriously to the mock codes; ▪ Staff not attending the Mock Code training class; ▪ Need to revise the form to include the oxygen flow rates; and ▪ Missing equipment or equipment that was not operational. The minutes also included an Action Plan for issues identified, action(s) to address the issue(s), the projected date of completion, the responsible person, and the evidence that would verify the issue was resolved. Although the committee was in the beginning stage of defining its goals and objectives, it appeared to be progressing in a very positive direction. Also since the last review, two additional staff were hired in the Competency Training Department and they were working with Nursing Education in conducting the Mock Codes. Also, the Facility had implemented a Mock Code Class in December 2010, which CTD staff and a CPR instructor taught. Staff who did not adequately perform during the Mock Drill were required to attend this class to ensure they were familiar with emergency procedures. In addition, staff received one-on-one instruction for problematic issues. This was another positive step the Facility had made in addressing some of the problematic issues that currently exist regarding Mock Drills. As the implementation of the system progresses, policies and procedures will need to be written and implemented outlining the system and addressing the Mock Code Class. Such policies should include a tracking system addressing staff attendance at the mock codes, timeframes for required attendance, and actions addressing lack of attendance. The Facility had added the CPR steps to the back of staff name badges for quick reference, and had added colored coding to the Do Not Resuscitate lists that were kept with the emergency equipment. The Facility also had added emergency equipment observations to the medication administration observations, to reinforce other training in this area. In addition, in November 2010, the Facility had ordered an additional four AEDs for areas such as the gym and the vocational site.	

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		A review of CCSSLC's Mock Medical Emergency Drills Checklists from July 2010 through November 2010 indicated that the Facility was conducting drills on a monthly basis in each unit and on each shift, in alignment with the Facility's policy. However, the Chief Nurse Executive (CNE) reported that the State policy, dated 7/21/10, indicated that each residence must participate in one drill per month, per shift, which would require more staff to run Mock Drills. In addition, the State policy indicted that areas providing limited direct services, such as the kitchen/dining room and administration areas, would participate in one drill per year. Vocational programs and other program areas that individuals routinely attended, would participate in one drill per shift, per site, per month. Clearly, a tracking system is needed to ensure that these areas participate in the required Mock Code Drills. A review of the Facility's drills found that additional issues had been identified during the Mock Code Drills, and that the Facility was beginning to incorporate the actual use of the emergency equipment during drills. However, all of the drills conducted consisted of CPR, and limited scenarios for either seizures or choking. No other scenarios were included in the drills, such as heat stroke, bee stings with anaphylactic shock, head injuries, or scenarios addressing first aid issues. The Facility should expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions other than CPR. Since the last review, the Facility had developed a tracking sheet indicating the date and time of the Mock Code, comments and concerns, any immediate plans of correction implemented, any systemic plans of corrections implemented, and the status of whether the staff passed or failed the drill. The structure of the tracking sheet lent itself to analyzing the information, and tracking problematic issues and the resolution of those issues. Based on the activity since the last review, the Facility had begun developing and implementing a very promising system for reviewing and analyzing emergency procedures, and the data generated from the emergency medical drills. In addition, the Nursing Education Department began tracking the trends of the emergency competency checks. The Facility's data for November 2010 indicated that of the 27 competencies completed, the following trends were identified: Use of Suction Machine: ▪ Four percent could not locate or demonstrate how to turn on the machine; ▪ Seven percent did not know the correct machine setting; and ▪ Four percent could not adequately trouble shoot problems with the machine's operation. Use of Oxygen:	

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		▪ Fifteen percent could not turn on the oxygen tank; ▪ Four percent could not attach the oxygen tubing to the regulator appropriately; and ▪ Fifty-two percent did not know the appropriate oxygen flow rates. Use of AEDs: ▪ Eleven percent did not know to inform the supervisor if battery was expired and that the backup battery was kept in the Infirmary; ▪ Four percent did not open the AED correctly; ▪ Seven percent could not identify the battery life of the AED; and ▪ Four percent did not know to contact the Campus Coordinator after using the AED. Observations of emergency equipment use by staff on the Kingfish unit found that the nurses were able to appropriately demonstrate the use of the oxygen and suction machines, but needed some prompting regarding the use of the AEDs. However, problems were found on the Emergency Cart Checklists from August 2010 through January 2011, including a number of blanks, which indicated that the emergency equipment was not being checked daily as required. The names of the residences were not listed on any of the Emergency Cart Checklists, making it impossible to determine which residences were not routinely checking and documenting the operational status of the emergency equipment. Also, there was no indication as to whether or not the backup AED battery, on the Infirmary Emergency Cart listed on the revised checklists, dated 8/27/10, was being checked. The Facility should develop and implement a system to ensure that the emergency equipment is checked and documented daily. Since the last review, the Facility had implemented spot checks for the use of the emergency equipment by the Nurse Educators. This was an excellent strategy for ensuring that all staff were familiar with the use of the emergency equipment, as well as identifying other problematic issues associated with the Facility's emergency systems. This "hands on" approach also allowed the Facility to promptly identify staff training needs regarding emergency procedures. The Facility should ensure it is documenting these spot checks and any problematic issues found, to allow the data to be aggregated with other Facility data regarding emergency response systems. This will help identify problematic trends and implement plans of correction. From the review of an actual Code (6333) for Individual #375, the Facility did not use any form such as the Mock Medical Emergency Drills form to record the timelines and processes of the actual medical code. The Facility should implement a form to record actual medical emergency codes, and the Mock Code Drills Committee should review this information to identify strengths and weaknesses in the Facility's emergency response systems.	

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		Since the last review, the Facility had implemented a number of interventions to address the emergency response systems. It was apparent that the Facility was taking this issue seriously and was committed to making the necessary improvements to ensure the existence of clinically sound emergency response systems, including adequate staff knowledge and competency with regard to emergency response procedures. Continued, consistent efforts in this area should ultimately result in compliance with the Settlement Agreement.	
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.	There had been no medical review by non-Facility physicians. The State Office had decided to use physicians from the other SSLCs to conduct physician case reviews and provide assistance. The State Office will need to guide the peer process to ensure an appropriate and thorough review is completed. This should include definition of the sample size, methodology (e.g., record reviews, interviews, etc.), topics of focus, (e.g., seizure management, aspiration, etc.), and report format.	Noncompliance
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.	A medical quality improvement process had begun to occur, but it will take time to build a system that includes adequate feedback, subsequent implementation of actions to effectuate change, and demonstration of impact. According to the POI, as of 12/15/10, a monitoring tool had been developed, and 10 records were reviewed using this monitoring tool. Other QA processes and tools were being developed with coordination between the QA Department and the Medical Department. As part of the QA process, the medical compliance RN conducted in-service training for PCPs and the dentist, covering the medical care policies in Sections L and LL of the Facility Policy Manual, with the goal of improving understanding, and promoting compliance. These occurred on 11/23/10 and 12/6/10. A copy was submitted of the monitoring tool, dated 11/10/10, which had been used to review medical records. This was a lengthy, detailed document (18 pages), and was inclusive of most areas of the medical record. Not all areas on the tool were relevant to all records. For instance, the section on seizure medications did not apply if the individual was not prescribed seizure medication. The sections included medical documentation, documentation of acute medical problems, addressing chronic health problems, PCP orders, integrated progress note documentation, consultation, hospitalizations/transfers/readmissions, annual plan of care/history and physicals, medical management of seizures, lab protocol for antiepileptic medications, psychotropic medications management, lab protocol for atypical antipsychotics, and lab protocol for	Noncompliance

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		antipsychotics. Ten records were reviewed on 11/27/10 and 11/28/10, and the results were submitted using this tool. It was not certain how this information would be processed and shared with the PCPs, and whether or not it would be discussed at a morning medical staff meeting or perhaps, most appropriately, at a medical staff meeting, which was a forum in which the PCPs could review and discuss the findings amongst themselves. With data beginning to be collected, the next step would be analysis and the development of action steps designed to lead to changes and improvements in clinical care. The tool was lengthy, labor intensive, and will likely show a variety of gaps, as well as areas in which work is done well. Once an area of need is identified, serial testing by repeating the parts of the tool that revealed the undesirable trend might be used, rather than repeating the entire 18-page tool. Additionally, the QA department had been developing a monitoring system to ensure implementation of the LL procedures, which are listed with regard to Section L.4 of the Settlement Agreement. It is also recommended that the quality review of medical care go beyond the current tools utilized and look at other information that is available. For instance, a list was submitted for those individuals who had been admitted to the emergency room. The numbers listed per month were as follows: 2/10 – nine ER visits, 3/10 – 14 ER visits, 4/10 – five ER visits, 5/10 - six ER visits, 6/10 – five ER visits, 7/10 – 15 ER visits, 8/10 – six ER visits, 9/10 - 10 ER visits, and 10/10 - nine ER visits. The first step would be to confirm the completeness of information, and ensure that all visits to the ER for acute problems were included in the database. Additionally, the current list submitted was problematic, because in many instances, the reason for the visit was not specified, but only listed as "response to medical emergency." The information being entered needed to be more clinically focused so as to be of value to the medical QA department. However, once this information is available, then trends related to the major causes of transfer to the ER could be reviewed, early interventions could be assessed (if they occurred), and a determination made as to whether or not health status changes were discovered promptly. This could then lead to more focused staff training. Early interventions might reduce the number of ER visits and hospitalizations. The data submitted for osteoporosis review could not be analyzed to determine if those with risk factors for osteoporosis had a DEXA scan in the past two years, what the readings were, and whether or not there was adequate treatment for those diagnosed with osteoporosis. This would be another area needing medical QA attention, with the first step being to gather the correct information.	

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		As mentioned with regard to Section L.1, there was an attempt to determine the rate of colonoscopy completion for those individuals ages 50 and over, but the information available was not helpful in addressing that issue. This would be another area requiring the attention of medical QA staff to determine and potentially increase compliance with standard preventive care.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The DADS Medical Care Policy #009, dated 7/20/10, provided the foundation on which the Facility policies were built. It referred to a number of documents that provided clinical guidance for medical care. These included: HealthCare Guidelines, including Appendix A: Pharmacy and Therapeutics Guidelines; US Preventive Services Task Force Guidelines, American Cancer Society Breast Cancer Screening policy (from *American Cancer Society Guidelines for Breast Cancer Screening: Update 2003,* A Cancer Journal for Clinicians 2003; 53; 141-169); American Cancer Society Breast Cancer Screening MRI policy (from *American Cancer Society Guidelines for Breast Screening with MRI as an Adjunct to Mammography*, A Cancer Journal for Clinicians 2007;57;75-89); Tuberculosis - Targeted Tuberculin Screening Form; and TB Questionnaire for Children. Consistent with State policies, and based on documents referenced in the State policy, a number of Facility policies had been written. These policies covered a wide array of subject matters central to the Medical Department, or provided guidance and structure to interdisciplinary aspects of care. These documents included the following: ▪ Participating in Medical Staff Meeting, draft revision 9/23/10; implementation 7/1/10; ▪ Medical Care L2: Tracking Annual Visual Screening/Acuity Testing, draft/revision 10/8/10; ▪ Medical Care L.3: State Center Assurances, draft/revision 11/4/10; ▪ Medical Care L.4: Health Care Documentation, draft/revision 11/4/10; ▪ Medical Care L.5: Hospitalization, Transfers, and Readmission, draft/revision 11/4/10; ▪ Medical Care L.6: Management of Acute Illness and Injury, draft/revision 11/4/10; ▪ Medical Care. L.7: Prevention, draft/revision 11/4/10; ▪ Medical Care. L.8: Quality Assurance, draft/revision 11/4/10; ▪ Health Care Guidelines (HCG) LL: Policy Statement; ▪ HCG: Medical and Nursing LL.1: Documentation, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.2: Medical Documentation – Active Problems List, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.3: Documentation of Acute Medical Problems, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.4: Addressing Chronic Health Problems,	Noncompliance

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		draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.5: PCP orders, draft/revision 11/4/10; ▪ HCG: Integrated Progress Note Documentation LL.6: Integrated Progress Note Documentation, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.7: Consultations, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.8: Hospitalizations and Transfers and Readmissions, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.9: Annual Plan of Care, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.10: Nursing Documentation, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.11: Seizure Management Overview, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.12: Seizure Management Medical and Nursing, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.13: Psychotropic and Positive Behavior Support Overview, draft/revision 11/4/10, approval 11/4/10, implementation 12/5/10; ▪ HCG: Medical and Nursing LL.14: Psychotropic/Positive Behavior Support Medical and Nursing, approval 11/4/10; implementation 12/5/10; ▪ HCG: Medical and Nursing LL.15: Management of Acute Illness and Injury, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.16: Management of Acute Illness and Injury – Medical and Nursing Expectations, draft/revision 11/4/10); ▪ HCG: Medical and Nursing LL.17: Prevention Overview, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.18: Prevention – Medical and Nursing Process Criteria, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.19: Nutritional Management Planning Overview, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.20: Nutritional Management Planning Process Criteria, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.21 Management of Chronic Conditions Overview, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.22: Management of Chronic Conditions – Medical and Nursing, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.24: Physical Management Overview, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.25: Physical Management Process Criteria, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.26: Pain Management Overview, draft/revision 11/4/10; ▪ HCG: Medical and Nursing LL.27: Pain Management Process Criteria, draft/revision 11/4/10;	

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		▪ Integrated Clinical Services G.1.2: Epileptic and Psychotropics Management, draft 11/23/10; and ▪ Providing HealthCare Services M.24: Seizure Management, approval 11/8/10, implementation 8/1/10 and 12/8/10. Although it was positive that this set of policies was developed, and generally appeared to be consistent with the health care guidelines, the policies need to be implemented to ensure adequate provision of care. In addition, they did not represent a full array of clinical pathways necessary to address the medical needs of individuals at CCSSLC. Many of the individuals continued to have recurrent problems due to diseases that commonly affect the IDD population. Standardization of care through the use of clinical pathways would assist the PCPs to determine the next step by providing options, one or more of which might be of benefit to the individual, and prompt decision-making in a timely manner. Examples of these individuals follow, some of whom were identified from the last Monitoring Team visit. <u>Aspiration, Pneumonia and Other Respiratory Illnesses, and GERD</u> Individual #179 developed pneumonia on 6/5/10, as well as on 7/17/10. He was admitted to the hospital on 10/4/10, and discharged on 10/12/10 for a bronchopneumonia. He was then admitted to the hospital 10/20/10 for pneumonia. At first, a right lower lobe pneumonia was identified, then this cleared, but then a left basilar pneumonia occurred. At that time, he was noted to have large amounts of residuals from his G-tube feedings. He also had a fundoplication and tracheostomy in the past. His tube feeding was continuous at 70 cc/hour. Although it is not certain that one or both pneumonias developed due to reflux and aspiration, the history of prior pneumonias and GERD placed him at high risk for GERD related pneumonias. A clinical pathway would assist the PCP to approach the next step in his care systematically. The individual already had a tracheostomy, fundoplication, and G-tube. There was no information provided to suggest further work up for GERD, whether the fundoplication was determined to be intact, or if he would benefit from a J-tube, or other more invasive surgical procedure. However, if the rate of pneumonias continued at four times a year, significant permanent pulmonary sequelae likely would occur with deterioration in health. Furthermore, meticulous training, reinforcement with direct support professionals, and constant monitoring would be needed to ensure appropriate positioning to not aggravate GERD. Individual #284 had had a number of pneumonias over the past year, including on 12/30/09, 3/26/10, 5/7/10, 7/20/10, 8/6/10, 10/25/10 (hospitalized until 11/8/10), and 12/17/10, as well as bronchitis on 8/16/10, and respiratory distress on 11/30/10. She had a G-tube, as well as a history of GERD and asthma. The contribution of GERD to her asthma was not known, but might be an important consideration to rule out.	

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		Additionally, despite the prolonged hospitalization starting 10/25/10, and the many bouts of pneumonia and respiratory illness, the annual medical assessment, dated 12/31/10, stated: "…has had a fairly good year. There were no hospitalizations or admits to the Infirmary." The quality of the annual medical assessments might need to be monitored by the medical QA nurse. A clinical pathway for GERD might assist in determining the role of reflux in her asthma and recurrent pneumonias, and provide potential options to reduce recurrent illness. If she had GERD, then this should be treated medically and/or surgically. Of additional concern, on 9/20/10, a nurse documented that the individual had been vomiting and had respiratory distress. When entering the room, the nurse observed the head of the bed to be "flat," with only five to 10 degrees of elevation. There was vomitus in the BiPAP mask. The mask was removed and the individual was suctioned. Positioning was problematic in this case. The direct support professionals need constant monitoring on all shifts, with frequent in-service reminders on the importance of positioning to prevent severe reflux and aspiration. Individual #22 had a G-tube placed for supplemental feeding on 5/7/08. She had three pneumonias in 2009. A modified barium swallow was completed on 9/3/10, and demonstrated that she was having silent aspiration. She was made NPO (Nothing By Mouth) and all feedings were currently through the G-tube. This was an appropriate follow up and next step. Individual #240 had a documented Barrett's esophagus. She had mild bronchospasm in 6/10. She was most recently fed through a G-tube. She was given four intermittent feedings at 200 ml/hour of 240 ml of formula, along with 140 ml water flushes four times daily. It was not clear if consideration had been given to a slower rate of continuous feeding to assist potentially in reducing GERD. Such suggestions/recommendations should be listed in a GERD clinical pathway. Individual #131 had numerous episodes of aspiration pneumonia in the past, as well as a history of GERD. A G-tube was placed. He developed pneumonia on 4/7/10 after aspirating vomitus. He also had pneumonia on 6/18/10. He was prescribed a proton pump inhibitor. He was prescribed Reglan, which was associated with the subsequent reduction of his regurgitation and vomiting. He received his feeding at a rate of 150 ml/hour four times a day (450 ml total each feeding). He was noted to have projectile vomiting on 9/26/10. Despite this, the nursing quarterly summary of 11/30/10 stated "he had no vomiting this past quarter." The nursing quarterlies are important sources of information, and such misinformation will only delay care or delay proper identification of clinical conditions. He had an Esophagogastroduodenoscopy (EGD) in 10/09 for coffee ground emesis, and remained anemic. He was referred to the gastroenterologist on 12/20/10. It was unclear if consideration had been given to a work-up to determine if GERD was a significant problem, and if so, what medical and surgical steps might be	

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		indicated. If GERD was a consideration, changing from an intermittent feeding to a continuous feeding might minimize reflux. A clinical pathway for GERD would assist in ensuring all areas are addressed, such as positioning, formula rate, as well as additional medication or surgical options. Use of Feeding Tubes Individual #43 had a G-tube and Nissen fundoplication in 2009 for aspiration pneumonia due to severe GERD. However, she continued to vomit (e.g., 12/3/09, 5/3/10, 5/10/10, and 6/24/10), and required hospitalization for aspiration pneumonia and sepsis on 1/26/10. A radiologic study was completed on 7/27/10, in which gastrografin was placed through the G-tube. There was brisk GE reflux to the thoracic inlet. She had a J-tube placed on 8/13/10. The G-tube was maintained and used to drain gastric secretions to prevent reflux of gastric acid and chemical pneumonitis. She saw a pulmonologist on 10/26/10, and it was suggested Maalox be given through the G-tube. There had been recurrent problems with the J-tube (e.g., on 9/6/10 the J-tube came out, on 11/28/10 the J-tube clogged, on 11/30/10 the J-tube came out, and on 12/17/10 the J-tube clogged). There was need for further training of direct support professionals and nursing staff on J-tube care. There are a number of steps involved in ensuring the J-tube does not get clogged, and also not inadvertently dislodged. The enteral tube feeding protocol should be reviewed to ensure it includes steps to avoid complications such as clogging and dislodging. Of note, the individual has had no pneumonias since the J-tube placement. Individual #380 had a G-tube and was on a proton pump inhibitor for GERD. On 8/23/10, it was reported that her G-tube was leaking. On 8/20/10, the staff noticed that the G-tube had come out and the balloon deflated. A policy for enteral tube maintenance to prevent such problems as leakage, dislodging, clogging, etc., would be valuable in guiding the nurses and direct support professionals in care of the tube. It would require intensive training of direct support staff. There should also be a tracking mechanism for replacement of tubes. If there was a trend toward deflated balloons leading to dislodgement or tubes with leaks, and the problem was not related to staff care, but a particular manufacturer had been identified, then changing stock orders and stock supplies would be important so as to minimize this occurrence. However, without a database or tracking system in place, this cannot be evaluated. Individual #183 had a history of rumination, and J-tube placement. The J-tube repeatedly was dislodged and fell out on 9/25/10, 10/6/10, 12/24/10, and 1/5/11. Nursing and direct support professionals should be provided training in care of the tube so as to not cause dislodgement. A policy or protocol should be developed, which addresses preventive measures of dislodgment, as well as tube maintenance. Individual #340 had a G-tube. On 6/28/10 and 10/4/10, the individual pulled the G-tube	

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		out, with the balloon intact. Additionally, drug order reports were obtained for four individuals with J-tubes. It was noted that Individual #43 received Ciprofloxacin from 9/11 to 9/23/10. Literature suggests this class of antibiotic might not be well absorbed through J-tube administration and alternative medications should be used. The Pharmacy Department should screen for medications prescribed for those individuals with J-tubes to ensure medications known to be poorly absorbed through this route are discussed with the PCP, and alternative choices are considered. Individual #207 underwent a Modified Barium Swallow Study (MBSS) on 11/1/10 due to meal refusals, spitting out food and medications, and difficulty taking fluids. Based on the MBSS, she was to continue with positioning at meals, thick-it to nectar consistency and pureed texture foods. Despite this information, the comprehensive annual exam of 12/1/10 indicated she required fluids thickened to pudding consistency. The PST met and agreed she needed an alternative route for nutrition, because she had a history of meal refusals, spillage, and spitting out medications, food and fluid. She had been hospitalized on 10/19/10 for pneumonia and hypotension. She developed a stage II decubitus of her sacrum in 11/10. The submitted information did not provide follow up information concerning the PST consideration. Reasons for pursuing or not pursuing supplemental feeding by a G-tube were not found. When the team reaches agreement on a decision, then it should be tracked through to closure. If there were other reasons not to pursue this decision (lack of justification and agreement from other departments or administration, disagreement from family, etc.), then it should be documented. <u>Osteoporosis</u> Individual #179 had a history of osteoporosis. However, according to the 8/3/10 annual medical assessment, he was only prescribed a Calcium supplement. Osteoporosis prevention guidelines suggest additional Vitamin D supplement, and osteoporosis treatment guidelines suggest additional pharmacotherapy. A clinical pathway would assist the PCP in providing timely, up-to-date treatment for this condition Individual #379 had a history of osteoporosis with a DEXA scan completed 9/23/10. She was started on Boniva on 10/13/10. She additionally was prescribed Calcium 500 mg three times a day. Vitamin D supplement is usually also given with the calcium, based on professionally accepted recommendations. Vitamin D levels are often used to track other clinical concerns (a history of deficiency when one is concerned about lack of absorption and response to treatment, or excessive dosing and toxicity), but adhering to national guidelines might be sufficient and efficient for osteoporosis prevention. A clinical pathway would assist in guiding the PCP in optimal osteoporosis prevention and treatment.	

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		Individual #355 had a history of osteoporosis, confirmed by a DEXA scan on 12/9/10, and was prescribed calcium. He also received testosterone injections, and IV Reclast was to be scheduled pending dental restorative work. A clinical pathway for osteoporosis would be valuable, considering the size of the population at CCSSLC diagnosed with this disease process. In this individual, a review of the dosage of calcium prescribed, as well as Vitamin D, would be important in order to ensure these dosages were consistent with national standards and recommendations. <u>Constipation</u> Individual #348 had a history of chronic constipation, for which she was prescribed Miralax 17 gm twice daily with 8 ounces fluid, lactulose 45 ml four times daily, Senna/docusate 8.6/50 twice daily, prune juice 4x daily, and an extra 240 cc fluid four times daily. On 7/17/10, she required a fleets enema. On 7/19/10, she required a fleets enema. On 7/21/10, she received an enema. On 7/30/10, she was given Milk of Magnesia (MOM). On 8/4/10, the Senna/Docusate was increased from once a day to twice a day. On 9/2/10, there was a consult to gastroenterology for her GERD and constipation, which was subsequently crossed off and changed to GERD only. According to the Integrated Progress notes, on 9/9/10, the nurse reviewed the bowel movement (BM) logs, and noted that there had been no bowel movement recorded in eight days. An exam did not reveal an impaction, and the nurse reported this finding to the MD. A fleets enema was given. On 9/14/10, a consult was again written to gastroenterology for chronic constipation. A fleets bisacodyl enema was given for three days without a bowel movement. This was given a second time the following day. A fleets enema was given 9/29/10 for no bowel movement in four days. A gastroenterology consultation report from 10/8/10 suggested the chronic constipation was due to immobility, medication, and "condition." She was on several medications, including psychotropics. This would be an opportunity for the Pharmacy Department to offer expertise in determining which medications, if any, would most likely be contributing to her constipation. If psychotropic agents were a possible significant causative factor, then discussion with the psychiatrist would be important, with documentation of discussion and any change in regimen. A clinical pathway for chronic constipation would provide guidance to the PCP concerning the next step and the timing of that step, and should include such aspects of appropriate work-ups, such as motility studies and medication drug reviews for significant side effects. Individual #228 was routinely administered Docusate 200 mg at bedtime (started 7/26/10), and Miralax three times a week (was restarted 8/23/10). Power pudding was increased to twice a day on 7/22/10. She required additional pro re nata (prn or "as needed") medication (i.e., enema, MOM, and/or Bisacodyl) on 7/19/10, 7/21/10, 7/23/10, 7/26/10, 8/19/10, 8/20/10, 8/27/10, 9/6/10, 10/11/10, 10/12/10,	

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		10/18/10, 10/21/10, and 11/9/10. Additionally, she was reported to have no bowel movement for five days as of 7/26/10. The reason was not given for the administration of frequent prn medication rather than adding an additional maintenance medication or increasing a dosage of a medication already being prescribed. Such frequent constipation impinges on the quality of life of the individual, and potentially the quality of health. A clinical pathway would provide guidance as to the rate of increase of medication, choices of medications, as well as any necessary work-up that would need to be considered. <u>Diabetes</u> Individual #211 had a history of diabetes insipidus. He received an extra 1000 ml of fluid daily between meals. Labs were drawn monthly. A clinical pathway would be a valuable tool in which to teach the direct support professionals signs and symptoms of worsening diabetes insipidus, so that an aggravation of the illness would be caught at an early stage. <u>Pressure Sores</u> On 11/24/10, Individual #43 developed a Stage 2 pressure sore, which was mapped and well documented. PT was consulted and the wheelchair was to be remapped for pressure points. A PUSH (Pressure Ulcer Healing Graph) was initiated, as well as a pressure ulcer healing record. By 12/15/10, the size had decreased, demonstrating the area was healing. The Facility took immediate action once the issue was identified. More problematic, however, was the reason for the occurrence and how to prevent reoccurrence. Dietary would need to review the formula being used, albumin levels might need to be monitored, positioning schedules should be written and reviewed regularly, staff should be monitored to ensure compliance for positioning, etc. The list of potential causes is lengthy, and a clinical pathway is needed to cover all areas of this multidisciplinary concern to ensure all areas are considered and preventive measures are in place. <u>Pica</u> Individual #87 had a history of pica, but currently did not have a BSP. His challenging behavior of pica was considered of low frequency and intensity. In the past, limiting his access to soft paper items controlled pica. On 11/16/10, an integrated progress note documented that he picked up paper off the floor, and swallowed some paper. The staff were able to retrieve the remaining paper in his hand. The individual was redirected and offered fluid. There was no other information submitted for review to suggest the team discussed this issue. Without a BSP or other written guidelines to address the pica, there would not necessarily be staff training and refresher training to ensure all staff were aware of his pica habit and the immediate response needed. There was no nursing or physician note that followed. The PSP Addendum of 1/5/10 documented he was on routine "level of supervision – not an issue/concern." Without a BSP or other specific	

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		guidelines to address the pica, it was not clear how the Facility would ensure the health and safety of this individual. Individual #7 had a history of swallowing inedible objects and required hospitalization with bronchoscopy on 1/2/10, and a thoracotomy in 2/09. More recently, she swallowed a paperclip on 9/24/10, a battery in 12/10, and a piece of glass from a broken mirror in 12/10, with additional claims to have swallowed part of a necklace in 12/10. Staff had been able to stop some ingestions (8/16/10 and 12/3-6/10). Numerous PSP addendums had been created, but the problem of her ingesting inedible objects continued to occur. Her level of supervision had been two-to-one. Despite this intensive oversight, she continued to ingest dangerous items. Further training of staff might be indicated, as well as monitoring to ensure they were following the plan. There might be a need for outside expertise, such as counterparts from other SSLCs or specialists in this area. The current PSP was not adequate due to the continued ingestion of dangerous objects. Individual #159 had a screening colonoscopy in 6/10, and 4x4 gauze was found in the lumen. There was little change in the Personal Support Plan Addendum. She had been on one-to-one supervision, but just during mealtimes. A number of clinical guidelines should be developed to provide guidance to PCPs, but also to other staff, regarding: GERD, maintenance of feeding tubes, constipation, osteoporosis, diabetes insipidus, decubitus care, and pica. Such policies would promote integrated clinical care and a team approach to care.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. For continuity of care, it will be important to continue to recruit physicians and physician extenders to fill any State employee position vacancies the department might have.
2. The department and administration should continue to pursue recruitment of a full time psychiatrist. Seeking advice or referrals from professional psychiatric societies/associations might be beneficial.
3. With regard to the morning medical meetings:
    a. The Medical Director should take a leadership and facilitative role in the morning medical meetings. The goal should be to encourage more discussion and critical thinking, and begin to develop action plans for cases discussed, going beyond the step of simply sharing information.
    b. Members at the meeting play an active role in identifying issues that need systemic improvement.
    c. The Medical Director should assign duties, tasks, and next steps, for unanswered clinical or administrative systems questions, either to members at the meeting or to departments represented, with a timeline of when the information will be shared at a future meeting.
    d. These assignments and timelines should be documented in the minutes.
    e. Minutes of the medical morning meeting should capture additional information. They should be a brief daily journal, and provide the

closure date and outcome for those medical problems mentioned in the reports reviewed each morning. Such information should include, but not be limited to, the closure of concerns mentioned in the daily log, and concerns significant enough to be signed off when one PCP is covering for another PCP. In addition, a log should be maintained that includes illnesses identified and treated during the day, which might not be included in the information reviewed at the morning meetings.

   f. The date should be included on each page of the minutes, and the logs should be matched to the date of the meeting, especially due to the many pages involved.

4. Infirmary rounds should continue to be held to ensure all PCPs are familiar with those individuals who are seriously ill, but also to develop a sense of community and teamwork among professionals.
5. With a change in medication, especially psychotropic medications, the pharmacy should review the orders similar to the way in which a new medication order is reviewed, ensuring the order is clinically appropriate as interpreted by the pharmacist.
6. A database, or other tracking system, should be used to assist in ensuring all clinical staff are current in their CPR certification. It is suggested that this be tracked by date of expiration of the CPR certification.
7. A database or other tracking mechanism should be developed and implemented to monitor preventive management, such as dates of colonoscopies, mammograms, etc.
8. If not already in place, a policy or directive should be developed and implemented to ensure that the annual medical assessment and annual physical exam are completed simultaneously, with a reason recorded when this is not possible. It also should clarify when an annual is overdue, such as 365 days from the prior annual medical assessment and physical exam.
9. The dates of the annual medical assessments and the annual physical exams should be tracked in a database or by another mechanism to ensure timely completion.
10. The Medical Director should review, and as necessary develop and/or revise the current policies and protocols for infections, infection control outbreaks, isolation, and quarantine.
11. The Medical Director should take a leadership role in potential Facility outbreaks.
12. The Medical Director should create a network of resources always available to provide guidance for any type of outbreak in a campus setting.
13. After an outbreak is resolved, the infection control committee should meet to analyze the series of events, and review areas needing improvement in the process (e.g., prompt response, communication between departments, documentation, etc.). It should also focus on preventing a recurrence of the outbreak.
14. A number of clinical guidelines should be developed to provide guidance to PCPs, but also to other staff, regarding: GERD, maintenance of feeding tubes, constipation, osteoporosis, diabetes insipidus, decubitus care, and pica. Such policies would promote integrated clinical care and a team approach to care.
15. Direct support professionals should be provided frequent in-service training concerning health status change, positioning during and after enteral feeding, as well as care of feeding tubes to prevent dislodgement.
16. The CPR training should be reviewed to determine if clear guidelines are taught regarding the appropriateness of moving an individual to a different location before beginning CPR, rather than initiating CPR at the location of occurrence.
17. Supervision should be carefully reviewed at PST meetings, especially for individuals with feeding tubes, or a history of pica. Plans should ensure the health and safety of the individual, and there should be full implementation of the plan.
18. Hospice use and palliative care should continue to be encouraged for those that qualify.
19. A mortality database (including age, cause, etc.) should be created to allow for future trend analysis and comparison with other facilities.
20. The DNR status of long-standing DNR orders should be reviewed periodically to confirm or rescind the earlier decision and order. Status II documentation should be updated on a yearly basis.
21. For highest risk individuals, including those frequently hospitalized, there should be nursing documentation of assessment on a daily basis at a minimum.
22. As applicable, staff should be provided an in-service on tracheal esophageal separations.

23. Training on J-tubes should include competency-based training on administration of medications, formula, and flushes, to minimize tube clogging.
24. Given the vulnerable population at Coral Sea, and especially for those unable to move when bitten by insects, a preventive extermination treatment schedule should occur. Additionally, if not already in place, Facility Administration should assign responsibility for a routine walk through of buildings to observe for such problems.
25. Clinical parameters (e.g., ER visits, hospitalizations, etc.) should be identified, and baseline data collected to allow for measurement of the impact of the implementation of the at-risk policy and aspiration pneumonia initiative to determine the degree of success and the potential need for improvements and/or change in policy.
26. The accumulative yearly seizure record and seizure disorder flow sheets should be completed monthly for the prior month.
27. It is imperative that the Medical Department be involved in the review and analysis of the Facility's emergency response systems through participation in the Mock Code Drills Committee.
28. Policies and procedures should be developed and implemented, outlining procedures and requirements related to the Mock Code Class, including a tracking system to address staff attendance, timeframes for required attendance, and actions addressing lack of attendance.
29. The Facility should develop and implement a tracking system to ensure that all designated areas in the Facility complete the required Mock Code Drills.
30. The Facility should expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions other than CPR.
31. The Facility should develop and implement a system to ensure that the emergency equipment is checked and documented daily.
32. The Facility should ensure it is documenting the spot checks for emergency equipment, and that any issues found are documented to allow aggregation of the data with other data the Facility has regarding emergency response systems. This will assist to identify problematic trends, and implement appropriate plans of correction.
33. The Facility should implement a form to record actual medical emergency codes, and the Mock Code Drills Committee should review this information to identify strengths and weaknesses in the Facility's emergency response systems.
34. The State Office should provide further guidance regarding the physician peer process in order to standardize the review process and sample size.
35. With the length of the medical record QA monitoring tool (18 pages), once a problem is identified, serial repetition of a section of the tool over time (providing monitoring of that problem) would be more efficient than repeating the entire tool. This process would also assist in ensuring the issue was resolved as corrective actions were implemented.
36. Data obtained from the medical QA reviews should be analyzed and results shared with the PCPs for comments and development and implementation of action steps.
37. Quality review should go beyond the record review and encompass other sources of data.
38. Information in the database for emergency room visits should provide brief, but important clinical details, such as the actual complaint/reason the individual was sent for evaluation and treatment.
39. With the many databases available and the inconsistency of some of the information, the medical QA program will initially need to focus on the quality of the information available to drive their decisions and initiatives.
40. The quality of the content of annual medical assessments should be a focus for and monitored by the QA nurse.
41. The Pharmacy Department should review and provide guidance on administering medication through J-tubes. Certain medications might have reduced absorption in the jejunum, and the Pharmacy Department should offer its expertise in this area to the prescribing PCPs.
42. PST decisions on clinical issues should be tracked to closure and documented in the Integrated Progress Note.
43. There continues to be an urgent need for development of policies, procedures, and a clinical pathway/clinical guidelines for treatment of pica. Such a clinical pathway/guideline should address the diagnosis process, testing to rule out medical causes, preventative, as well as acute care and treatment, and the protective measures that should be considered by the interdisciplinary team, including medical staff.

44. With each episode of pica, the PST should determine the next step. Continuing the same plan that failed allows the risk to continue. For challenging pica behaviors, obtaining second opinions from outside the Facility or outside the DADS system should be considered.
45. Transition packets should have a standard set of medical information available that is user friendly to the receiving physician's office. All important information should be condensed on a few typed forms, that are updated at the time of the transition and easy to read. A list of pending follow up needs and appointments would be helpful to ensure no lab test or consultation is missed. A contact person with access to the individual's record should be listed to provide clarification or additional information. A list is provided in Section L.1 of the essential documents that should be considered in standardizing the packet.
46. The Facility should continue its efforts to develop a medical quality assurance/improvement system. As these more formal processes for assessing compliance with the Settlement Agreement are developed, resulting data and analyses of that data should be included in the Facility's POI to supplement the valuable narrative information describing the Facility's efforts toward compliance.

The following are offered as additional suggestions to the State and Facility:

1. For efficiency, the various reports (24-hour nursing reports, Infirmary reports, hospital reports) should be collected and copied ahead of the morning meetings. There might be a need to assign someone specifically to this task.
2. For Infirmary rounds, notes should only include abbreviations the Medical Department has approved. This would improve understanding of the notes, and also prevent misinterpretation.
3. For efficiency, the Facility should consider providing the Hospital Liaison Nurse with a laptop.
4. It is suggested that the annual medical assessments and annual physical exams be completed by 30 days prior to the due date to ensure all assessments have been completed by the due date.
5. For potential failure of devices and apparatus (i.e., feeding tubes), the Facility would benefit from a tracking system to identify the more reliable products available.
6. For those transported to the hospital for direct admission or sent to the ER, the transfer packet of information should include a document CCSSLC maintains with the signature of the person receiving the packet, as well as the date and time the packet was received.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC's POI; o CCSSLC's Nursing Supplemental POI; o CCSSLC's Nursing Staffing levels; o CCSSLC's Nursing Department Presentation Book; o Statement of the Function of the Infection Control Nurses, Policy A.02, dated 11/22/10; o Position Description for Assistant Infection Control Nurse; o Position Description for the Nursing Administration Coordinator; o Position Description for Program Compliance Nurse; o Quality Assurance Committee – Nursing, Policy M.25, dated 11/17/10; o QE Nurse's Health Monitoring Tool Audit reports for September through November 2010; o Nursing Quality Assurance minutes, dated 7/15/10, 8/5/10, 9/9/10, 10/20/10, and 11/8/10; o Nursing Meeting minutes, dated 8/20/10, 9/17/10, 10/15/10, and 11/19/10; o Nursing Peer Review Meeting minutes, dated 7/22/10, 8/26/10, 9/15/10, 10/28/10, and 11/15/10; o Draft CCSSLC Policy: Responding to Acute Medical Problems, dated 12/22/10; o Draft State Policy: Management of Acute Illness and Injury, dated December 2010; o Draft State Policy: Medication Administration Guidelines, dated December 2010; o Draft State Policy: Nursing Documentation Guidelines, dated December 2010; o Draft State Nursing Protocol: Pre-treatment and Post-Sedation Monitoring, dated December 2010; o Draft State Nursing Protocol: Seizure Management, dated December 2010; o Draft State Policy: Competency-based Training Curriculum-Agency/Contract Nurses, dated November 2010; o Health Care Services Policy: Educational Peer Review, dated 8/27/10; o Completed monitoring tools from the Program Compliance Nurse; o QE Nurse's monitoring tool data; o Respiratory Therapy-Nebulizer Policy, dated 11/15/10; o Draft Policy: Filing, dated 11/4/10; o CCSSLC's nursing staffing vacancies; o Resume for RN Consultant from Coastal Bend College; o Curriculum for overview training regarding Nursing Care Plans conducted on 10/15/10; o Revised Emergency Cart Checklist form; o Medication Observation data for October 2010; o Eighty-eight completed Medication Administration Observation forms; o CCSSLC's Medication Variance data; o Infection Control Committee Meeting minutes, dated 9/9/10, and 12/9/10; o Pharmacy and Therapeutics Committee Meeting minutes, dated 7/6/10, 9/8/10,

	10/22/10, and 12/14/10; o CCSSLC's Comprehensive Nursing Assessment training rosters; o The competency-based training curriculum for the Comprehensive Nursing Assessment; o Draft of the Risk Guideline Packet; o Facility training rosters; o Medication Administration Workgroup minutes, dated 5/3/10, 5/17/10, 6/21/10, 6/28/10, 7/5/10, 8/2/10, and 9/24/10; o Medication Error Committee minutes, dated 5/27/10 (not held due to lack of quorum), 6/24/10 (not held due to storm), 7/22/10 (not held due to lack of quorum), 8/6/10, 10/15/10, and 11/30/10; o Timeline for Scabies Outbreak; o CCSSLC's Individuals at High Risk By Type list; o Documentation regarding competency based training and Infection Control from Valerie Kipfer, RN, MSN, State Nursing Consultant; o Medical records for the following: Individual #311, Individual #173, Individual #58, Individual #270, Individual #130, Individual #84, Individual #94, Individual #170, Individual #7, Individual #21, Individual #338, Individual #43, Individual #183, Individual #255, Individual #186, Individual #218, Individual #114, Individual #109, Individual #158, Individual #88, Individual #323, Individual #203, Individual #95, Individual #231, Individual #41, Individual #6, Individual #318, Individual #267, Individual #302, Individual #242, Individual #174, Individual #92, Individual #62, Individual #193, Individual #359, Individual #53, Individual #94, Individual #151, Individual #277, Individual #237, Individual #246, Individual #325, Individual #30, Individual #295, Individual #238, Individual #342, Individual #161, Individual #43, Individual #324, Individual #245, Individual #68, Individual #101, Individual #366, Individual #36, Individual #37, Individual #350, Individual #28, Individual #319, Individual #236, Individual #146, Individual #50, Individual #290, Individual #334, Individual #222, Individual #195, Individual #181, Individual #240, Individual #299, Individual #252, Individual #24, Individual #163, Individual #145, Individual #137, Individual #89, Individual #150, Individual #291, Individual #67, Individual #270, Individual #154, Individual #273, Individual #304, Individual #266, Individual #128, Individual #131 Individual #153, Individual #240, Individual #325, Individual #117, Individual #2, Individual #31, Individual #19, Individual #294, Individual #356, Individual #202, Individual #181, Individual #174, Individual #62, Individual #109, Individual #336, and Individual #315, Individual #228, Individual #103, Individual # 223, Individual #278, Individual #207, Individual #375 Individual #357, Individual #101, Individual #76, Individual #79, Individual #9, Individual #51, Individual #32, Individual #263, Individual #86, and Individual #42; o CCSSLC's Infection Control computerized surveillance data list; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually

	transmitted diseases (STDs); and o CCSSLC's lists of individuals who were seen in the emergency room, hospital, and Infirmary. ▪ **Interviews with**: o Colleen M. Gonzales, BSHS, Chief Nurse Executive; o Rhonda Lynn Warner, RN, QA; o Dr. Sandra Rodrigues, Medical Director; o Jennifer Urban, RN, BSN, Nursing Operational Officer (NOO); o Peggy Sue Miclan, RN, Program Compliance Nurse; o Della Cross, RN, Nurse Educator; o Kristen Middleton, RN, Nurse Educator; o Elvira Obregon, RN, Assistant Infection Control Nurse; o Valerie Kipfer, RN, MSN, Nursing Services Coordinator, Texas Department of Aging and Disability Services; o Colleen L. Eaves, RN, Nursing Administration Coordinator; o Elizabeth Rovira, RN; o Jeneba Jones, RN, Nurse Manager; o Roger R. Silva, RN, Nurse Manager; o Laura A. Ramon, RN, Case Manager; o Stefanie D. Martinez, RN; and o Althea Stewart, RN, Medical Compliance Nurse for Medical Services. ▪ **Observations of**: o Medication administration at Sand Dollar; o PST Meeting for Individual #338 on 1/6/11; and o Use of emergency equipment at Kingfish.
	Facility Self-Assessment: Based on a review of the Facility's POI with regard to Section M of the Settlement Agreement, the Facility found that it remained out of compliance with the all of the indicators. Although the Monitoring Team was in agreement with these findings, it was not clear if the Facility based this conclusion in part based on any objective data generated from the monitoring processes implemented from the last review. Since the last review, the QE Nurse and the Program Compliance Nurse had generated well over 600 completed monitoring tools in the various areas for nursing. Since the last review, the Facility had developed appropriate instructions for each of the nursing monitoring tools, which identified the specific criteria that constituted compliance with each item. Although the Facility reported that inter-rater reliability was established for the nursing tools, the Facility did not have a written procedure outlining the process to ensure the inter-rater reliability process was executed appropriately and consistently. In addition, the percentages of inter-rater reliability were not reported for each tool as would be necessary in evaluating the reliability of the overall data collected. The Facility's POI indicated that the QA Nurse and the Program Compliance Nurse completed a significant number of audits without first establishing inter-rater reliability. The usual progression for this process would include developing instructions for the tools, and then establishing inter-rater reliability before

	initiating auditing activities to ensure that the data generated accurately reflected the indicators being audited. In addition, establishing an appropriate structure to guide the entire monitoring process would ensure that all disciplines were using the same procedure so that data across disciplines was accurate and reliable. Without accuracy and reliability, the analysis and interpretation of the data could easily be skewed and trends not accurately identified. As previously noted, the Nursing Department had generated a tremendous amount of data, albeit of questionable reliability. The nurses' enthusiasm and drive in wanting to move forward had been exceptional. However, this energy should be focused so that systems are appropriately implemented and energy not wasted on procedures that do not yield the expected outcomes. Regarding data generated from the monitoring process, the Facility should develop a unified system to present the data from the monitoring tools in a meaningful way so that the data can be easily analyzed and trends identified. In addition, a unified system would also allow data to be easily reviewed and interpreted between disciplines and departments. As noted in previous reports, the presentation of data should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured. Once this data presentation system is developed, the Facility will then need to use this data to justify their compliance status for the various monitoring indicators. On a positive note, the Facility's POI for Nursing included much more information with specific dates of implementation and updates on systems' status. In addition, the Presentation Book addressing the Settlement Agreement requirements and the Nursing Department's supporting documentation was impressive and very detailed. Without question, this facilitated the review process and provided a comprehensive overview of the steps taken, progress made, and movement toward compliance.
	Summary of Monitor's Assessment: Although not in compliance with the requirements of the Settlement Agreement, the Nursing Department's commitment to moving toward compliance was obvious through the number of systems that the department had implemented since the last review. A number of these accomplishments detailed further in the sections below that address each of the requirements of Section M of the Settlement Agreement. CCSSLC continued to have adequate nursing staff and had fewer vacancies than during the last review. The Chief Nurse Executive had filled a position for a full-time Program Compliance Nurse dedicated to the monitoring process. The Chief Nurse Executive had reallocated a full-time position for a Nursing Administration Coordinator, which was filled in November 2010. Also, a position for a Medical Compliance Nurse was implemented in December 2010 to assist the Medical Department with monitoring activities. This position was not under the Nursing Department, but rather the Medical Department. However, the person in this position worked closely with the Nursing Department. At the time of the review, the Facility had developed appropriate job descriptions/job duties addressing these new hires and/or newly allocated positions. The Facility had continued to not need the use of any agency nurses.

	CCSSLC's QE Nurse and the Program Compliance Nurse each conducted monitoring activities for different areas using the Facility's nursing tools. Since the last review, the Facility had developed appropriate instructions for each of the nursing monitoring tools, which identified the specific criteria that constituted compliance with each item. Although the Facility reported that inter-rater reliability was established for some of the nursing tools, no written procedure was found outlining the process to ensure the inter-rater reliability process was executed appropriately and consistently. In addition, the Facility had developed a draft of the Quality Assurance Committee – Nursing Policy M.25, dated 11/17/10. The purpose of the committee was to establish a systematic approach to monitoring and analyzing information to improve the quality of care and services the Nursing Department provided to the individuals at the Facility. The committee was to meet monthly to review and analyze the data generated from the Health Monitoring Tools or other monitoring systems, and identify trends. The information from the Quality Assurance Committee-Nursing would be reported monthly at the Facility's QA/QI Council. This was an excellent forum for the review and analysis of nursing's monitoring data, and integrated it into the Facility's QA system. Consistent with the past review findings, significant problems were found regarding the quality of the care regarding acute illnesses, Nursing Assessments and Nursing Care Plans. Since September 2010, the department had initiated using monitoring tools related to urgent care and acute illnesses/injury for all individuals who had been admitted to the hospital, emergency room, or Infirmary. The Facility reported that between July 2010 through November 2010, 66 audits had been completed for this population. Although the Facility's POI indicated that they were slowly seeing improvements in the documentation for urgent care and acute illness and injuries, the findings of the Monitoring Team did not support these improvements. Since the previous review, the Nursing Department had continued to implement a number of interventions addressing the medication administration system. The Medication Administration meeting had been merged with the Medication Error Committee. The Medication Observation tool was again revised to include an item prompting a review of the Emergency Checklist in the home to ensure it was being filled out daily indicating that staff was checking the operations of the emergency equipment. This was a positive addition, since a review of the Emergency Cart Checklists from August 2010 through January2011 found that there were a number of blanks indicating that the emergency equipment was not being checked daily as required. In addition, the Facility had developed a database for the Medication Observations in order to aggregate the data generated from the observations and had begun to identify trends.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different nursing sub-sections that address various areas of compliance as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include	Noncompliance

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	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.	staffing, quality enhancement efforts, assessment, availability of pertinent medical records, and infection control. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2, and M.3 of the Settlement Agreement. Information addressing Mock Code Drills and Emergency Response Systems is included in Section L.1. Staffing Since the last review, CCSSLC had 62.7 positions allotted for Registered Nurses (RNs) which was a slight increase since the baseline review (1.7) with 6.2 vacancies, and 51.5 positions for Licensed Vocational Nurses (LVNs), which was also a slight increase since the baseline review (1.5), with no vacancies according to the Chief Nurse Executive (CNE) and the Facility's Supplemental POI. The CNE reported during the review that the nursing staffing remained stable even with the current RN vacancies. The Chief Nurse Executive had reallocated a full-time position for a Nursing Administration Coordinator, which was filled in November 2010. The Program Compliance Nurse position, which was posted in March 2010, was filled. This position collaborated with the QE Nurse regarding auditing issues and worked from 2 p.m. to 10 p. m. on Mondays and 2 p.m. to 6 a.m. on the weekends. At the time of the review, the CNE reported that the additional position for a Wound Care Nurse that had been being evaluated was not being considered at this time due to other priorities. Also, a position for a Medical Compliance Nurse was implemented in December 2010 to assist the Medical Department with monitoring activities. This position was not under the Nursing Department, but rather the Medical Department, but collaborated closely with the Nursing Department. At the time of the review, the Facility had developed appropriate job descriptions/job duties addressing these new hires and/or newly allocated positions. As policies are reviewed and/or revised, the Facility needs to ensure that policies, procedures or protocols address the integration of these new nursing positions into the Nursing Department. Consistent with the previous reviews, CCSSLC continued to maintain an adequate and consistent nursing staff. The Facility fortunately had continued not to need the services of agencies to augment the nursing staffing coverage. Nursing students from the local nursing schools continued to come to the Facility for clinical training. Although the nursing staffing has remained stable, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. At the time of the review, CCSSLC had a census of 283 individuals. The structure of the Facility's nursing services remained the same since the previous review with one exception noted below:	

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		▪ The Infirmary and Sand Dollar continued to be the two residential buildings that provided 24-hour nursing care. ▪ During the day, nurses were assigned to each building. During the night shift, the Facility utilized a Campus Nurse who made rounds, and covered the rest of the Facility that did not have nursing coverage. ▪ The nursing staffing assignments at CCSSLC continued to include five Nurse Managers, and a group home manager. The Facility's two Psychiatric Nurses that were assigned to the Psychiatric Clinic were moved from being under the Nursing Department to the Medial Department. ▪ The direct supervision of the Hospital Nurse Liaison, Nurse Educators, the Infection Control Nurse, the Nurse Operations Officer, an Administrative Assistant, Medical Appointment Secretary, the Lab Technician, and the Transporter continued to be provided by the CNE. Quality Enhancement Efforts From interviews with the QE Nurse and the Program Compliance Nurse, each conducted monitoring activities of different areas using the Facility's nursing review tools. Since the last review, the Facility had developed appropriate instructions for each of the nursing monitoring tools, which identified the specific criteria that constituted compliance with each item. Although the Facility reported that inter-rater reliability was established for some of the nursing tools, no written procedure was found outlining the process to ensure it was executed appropriately and consistently. In addition, the Facility had developed a draft of the Quality Assurance Committee – Nursing Policy M.25, dated 11/17/10. The draft policy noted that the purpose of the committee was to establish a systematic approach to monitoring and analyzing information to improve the quality of care and services the Nursing Department provided to the individuals at the Facility. The committee was to meet monthly to review and analyze, the data generated from the Health Monitoring Tools or other monitoring systems, and identify trends resulting. A sampling procedure was described that would be used to pull samples for a variety of different areas included in the Health Monitoring Tools, such as Infection Control, Prevention, At-Risk Individuals, Nursing Care Plans, and Urgent Care. Corrective Action Plans would be developed based on the identified trends to remedy and/or prevent the reoccurrence of these trends. In addition, the policy indicated that the QE Department would track the progress of the corrective action plans, and conduct program audits to validate the implementation of recommendations identified. Also, the information from the Quality Assurance Committee – Nursing would be reported monthly at the Facility's QA/QI council. This is an excellent forum for the review and analysis of nursing's monitoring data and integrated it into the Facility's QA system. As the committee refines its process over time, it should consider establishing a percentage of the overall recommendations generated from the corrective action plans to	

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		review to ensure that recommendations are in fact being timely and appropriately implemented. At the time of the review, the QA Nurse was auditing the following areas: ▪ Nursing Assessments, both Quarterly and Annual; ▪ Documentation; ▪ Prevention; ▪ Health Care Plans; ▪ Dental; ▪ Pharmacy; and ▪ Medication Observations. From the minutes of the Nursing Quality Assurance meetings, it appeared that the QA Nurse and the Program Compliance Nurse completed a number of audits without establishing inter-rater reliability. Once instructions for the tools have been developed, inter-rater reliability must first be established for the tools, and then auditing activities should be initiated. As mentioned previously, the Facility should develop a procedure addressing establishing inter-rater reliability so that all disciplines understand the process and execute it consistently. Without question, the Nursing Department's enthusiasm and commitment regarding initiating the Health Monitoring Tools was impressive. However, establishing an appropriate structure to guide the process is necessary in order for the data generated to be accurate and reliable. Without accuracy and reliability, the analysis and interpretation of the data could easily be skewed and trends not accurately identified. A review of the QE Nurse's Health Monitoring Tool Audit reports for September through November 2010 found that the methodology for sampling was clearly stated, as well as the specific areas audited. These reports appeared to focus on the comparison compliance scores between the QE Nurse and Program Compliance Nurse in attempts to establish inter-rater reliability. However, from the way the report was structured, it was difficult to discern what exactly the data meant. In order to clarify the information, it would be helpful to present the established inter-rater reliability score with the data, and the compliance data as an overall compliance score for each item on the specific tool used. In addition, the reports should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Sample size needs to be established, and in doing so, the ability to apply the findings to the overall population needs to be considered. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured.	

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		Some of the findings pulled from the comments sections of the QE Nurse's auditing tools included the following: ▪ Inconsistencies in the documentation format; ▪ Documentation illegible; ▪ Dental using abbreviations not on Facility approved list; ▪ Needing clarification from pharmacy regarding auditing responsibilities; ▪ Outdated information contained in Annual Nursing Assessments; ▪ Nursing Care Plans not initiated for active medical problems; ▪ Signatures missing from Nurses' notes; ▪ No documentation regarding new medications started; ▪ Lack of follow up for PRN medications; ▪ No times noted on Nurses' notes; ▪ Problems not regularly documented up to resolution; and ▪ No documentation indicating that interventions from care plans were being implemented. At the time of the review, there was no system in place addressing the structure of how data was presented for interpretation. As the Facility gains more experience generating data from the Health Care Monitoring tools, a unified system should be developed to present the data from the monitoring tools in a meaningful way so that the data can be easily analyzed and trends identified. A unified system also would allow data to be easily reviewed and interpreted between disciplines and departments. The table below is one possible system for the Facility to consider as a simple structure for standardizing the presentation of the data.	

Name of the Health Care Monitoring Tool
Established Inter-rater reliability percentage

Month/year data collected	1/11	2/11	3/11	4/11	5/11	6/11	Mean
N							
n							
% Sample Size							
# ITEM 1 (Item # on tool and the Item being monitored)	Compliance scores for item #1 by month						Mean Compliance score for item #1
# Item 2	Compliance scores for						Mean Compliance

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		(continued below)	

	item #2 by month						score for item #2
# Item 3	Compliance scores for item #3 by month						Mean Compliance score for item #3

N = Number of total population being reviewed (for example: Total number of Individuals with Diabetes) in the review month.
n = Number of records audited (for Individuals with Diabetes)

Item #	Mean Previous Review Period	Mean Current Review Period
#1		

Although the Facility had developed instructions for each of the nursing monitoring tools, the State also had developed instructions for the Health Monitoring Tools and had submitting them for feedback to the Facility. A review of the feedback on these tools found that the QE Nurse had conducted a very comprehensive review of the State's revised Health Care Guidelines Monitoring Tools, and had identified some possible problematic issues that could potentially cause errors or confusion in the auditing process. The Facility should ensure that the findings of the QE Nurse are provided to the State for review.

From interviews with the QE Nurse and review of the QE monitoring data, the Facility had invested extraordinary efforts into the development and implementation of the monitoring system. There was clearly frequent and consistent communication between the QE Nurse, the Program Compliance Nurse, and the Nursing Department regarding the monitoring process and initial trends identified. The minutes of the Nursing Quality Assurance meetings, the Nursing Meetings, and the Nursing Peer Review Meetings clearly indicated that the monitoring process was routinely discussed and the problematic trends that were identified had corrective action plans developed. In addition, staff who were identified as having strong documentation were recognized. While the monitoring responsibilities between QE and the Program Compliance Nurse had been defined, the next steps would entail formalizing the inter-rater reliability process, and establishing a unified structure for presenting the data generated from the Health Care Monitoring tools. The QE Nurse, Program Compliance Nurse, and the Nursing Department should continue to ensure that they are critically auditing clinical issues, and focusing on the quality of the nursing services provided and not the just completion of required documentation.

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		<u>Assessment and Documentation of Individuals with Acute Changes in Status</u> In September 2010, the Facility had implemented a system whereby when an individual was admitted to the Infirmary, community hospital, or emergency room, one of a pool of selected staff were notified so that they could assist the staff in reviewing the episode and the associated documentation, and make recommendations regarding the documentation. In addition, the Facility had implemented a procedure for educational peer review for cases in which the individual was admitted to the Infirmary, community hospital, or emergency room. The core Peer Monitoring Team consisted of the CNE, Nurse Operations Officer, Nurse Educator, Infection Control Nurse, the QE Nurse, and the Hospital Liaison. Also, since the last review, the Nurse Manager and Case Manager of the individual reviewed were included in the Peer Review process. From discussions with the Chief Nurse Executive, the interventions described above had not yet resulted in any significant changes in the documentation or on clinical outcomes. A review of 13 individuals' medical records (Individual #311, Individual #173, Individual #58, Individual #270, Individual #130, Individual #84, Individual #94, Individual #170, Individual #7, Individual #21, Individual #338, Individual #43, and Individual #183), who had been transferred to a community hospital, emergency room, or the Infirmary, found that the significant problems regarding nursing assessments and documentation identified during the past two reviews continued to be significant problems, including the following: ▪ A lack of recognition that the symptoms the individuals experienced were signs of changes in status and warranted nursing assessments and documentation of the findings from assessments; ▪ Nursing not responding or timely responding to the concerns of direct support professionals regarding assessing an individual's status; ▪ Nurses not consistently documenting the type of temperature taken; ▪ Inconsistent follow-up from issues noted in previous nurses' progress notes; ▪ A lack of specific descriptions regarding size, and exact location of injuries, skin abnormalities, or rashes; ▪ A lack of documentation of surgical site assessments; ▪ Lack of documentation regarding when exactly a PRN (as needed medication) was administered, by whom, and appropriate description of effectiveness; ▪ Lack of recognition that PRNs indicated a change of status and warranted a nursing assessment related to the clinical reason for the PRN; ▪ Lack of adequate assessments and follow-up for pain; ▪ Lack of mental status assessments documented during periods of status changes; ▪ Inappropriate and non-specific documentation of lung sounds; ▪ A lack of lung sounds routinely assessed and documented for respiratory issues;	

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		▪ A lack of neurological checks documented for individuals with a significant change in mental status and levels of consciousness; ▪ A lack of assessment of bowel sounds and palpation of the abdomen for individuals with constipation and receiving PRNs for constipation; ▪ Physician/Practitioner not timely notified when changes in status began to occur; ▪ A lack of documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ Nurses' progress notes that did not indicate exactly when issues occurred in chronological order; ▪ Nurses' progress notes that lacked adequate objective data; ▪ Nurses' progress notes that lacked specific descriptions of individuals' behaviors and mental status, assuming that all staff reading the progress notes were familiar with the individuals (e.g., "back to normal," or "back to his old self"); ▪ No indication if oxygen saturations documented were reflective of room air; ▪ The lack of analysis of contributing problematic issues affecting change of status; ▪ Several inappropriate abbreviations; ▪ A lack of adequate assessments documented regarding the individual's status and mental status at the time of transfer to and from the Infirmary, hospital, or emergency room; ▪ Inconsistent documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred; ▪ Inconsistent documentation that the nurse or physician notified the receiving community facility of the individual's transfer; ▪ Inconsistent documentation of the exact time, date, and/or method of transfer to the receiving facility in the progress notes; ▪ Lack of a complete nursing assessment upon return to the Facility, especially addressing the very symptoms that precipitated the transfer; ▪ The lack of on-going follow-up assessments after transfer back to the Facility addressing the symptoms that precipitated the transfer; ▪ Missing dates and times on progress notes; ▪ Inconsistent use of Subjective, Objective, Assessment, and Plan (SOAP) format for progress notes, which had been adopted by CCSSLC; ▪ Nursing Care Plans not updated to reflect changes in status and new interventions; and ▪ Illegible nursing progress notes. Based on a review of 13 records for individuals who had experienced a change in status that required an admission to the Infirmary, community hospital, or emergency room, there was documentation that: ▪ Nurses promptly and consistently performed a physical assessment on an	

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		individual displaying signs/symptoms of potential or actual acute illness in zero (0%). ▪ Licensed nursing staff timely informed the PCP of symptoms that required medical evaluation or intervention in zero (0%) cases. ▪ Appropriate information was communicated to the PCP in zero (0%) cases. ▪ The nurse performed appropriate and complete assessments as dictated by the symptoms in zero (0%) cases. ▪ The nurse conducted frequent assessments of the individual's clinical condition in zero (0%) cases. ▪ A plan of care was developed including instructions for implementation and follow up assessments in zero (0%) cases. ▪ The documentation indicated that acute illness/injuries were followed through to resolution in zero (0%) cases. ▪ Upon discharge from receiving facility, there was a complete nursing assessment performed in zero (0%) cases. These findings were similar to the findings from the baseline and the previous reviews. Thus far, there had been no noticeable improvement in the nursing care and documentation regarding acute illnesses. As an example of some of the problems noted: ▪ In the case of Individual #311, on 9/17/10, the nurses' progress notes indicated that he had a reddened area and a skin tear to the intergluteal cleft (the area between the buttocks that runs from just below the sacrum to the perineum) "possibly from soiled depends." The note indicated that the physician was notified, and had ordered a treatment, and would see the individual in the clinic. A review of the notes found that there was no note indicating that the physician saw and assessed the individual. In addition, there were no nursing notes until 9/21/10, indicating that the individual was not being regularly assessed, that interventions were not being implemented to ensure that he was promptly provided personal hygiene measures when incontinent, and/or that the condition of the skin tear was being daily observed. In addition, there was no documentation of an assessment of the skin on other areas of his body to identify any reddened areas. Also, there was no indication that the direct support professionals were given instructions regarding his personal hygiene, were observed to ensure he was receiving appropriate hygiene measures, or were instructed to report any changes in his skin or status to nursing. The nurse's note on 9/21/10, indicated that the individual continued to have a skin tear, however, there was no complete assessment conducted and documented. The next nurses' note was dated 10/1/10, illustrating that nursing had not assessed the individual for nine days.	

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		The nurse's note on 10/1/10 indicated that the individual "was not acting himself," but did not give specific information regarding the changes that were observed. In addition, the note indicated that his temperature was 99.6 axillary. Axillary temperatures are considered to be the least reliable temperatures and require that three degrees usually be added for a more accurate reading. Thus, the individual's temperature would have been closer to 102 degrees, indicating he had a fever. However, the nurse's note stated that the individual was afebrile, and no other nursing assessment was conducted. The note stated "will continue to monitor his respiratory status tonight." However, there was no nurse's note found until 10/4/10, which did not include an assessment of the individual. The nurses' noted on 10/5/10 indicated that the nurse heard "course rales even with a stethoscope," skin was pale and individual "sounds as if he is having difficulty breathing." No actual lung sounds were documented and no vital signs were obtained. This indicated that the individual was having "possible respiratory distress." However, there was no indication that the physician was notified at that time. The notes indicated that an hour after this entry, the individual was sent to the hospital. However, no nursing assessment was found prior to his transfer to the hospital, where he was admitted from 10/5/10 through 11/9/10 for left lung pneumonia and pneumothorax (a collapsed lung) requiring the placement of chest tubes. Upon his return to the Facility, the nurses' notes did not document on-going nursing assessments addressing his respiratory status including his lungs sounds. Although the Facility recently had implemented a system for "real time" mentoring for this area, significant problematic clinical issues were consistently found similar to the last two reviews. As this area is a priority, the Facility should aggressively focus on strategies that will address the significant lack of nursing clinical judgment that is pervasive throughout the Facility. From discussion with the CNE, since September 2010, the department had initiated using monitoring tools related to urgent care and acute illnesses/injury for all individuals who had been admitted to the hospital, emergency room, or Infirmary. The Facility reported that between July 2010 through November 2010, 66 audits had been completed for this population. Although the Facility's POI indicated that they were slowly seeing improvements in the documentation for urgent care and acute illness and injuries, the findings of the Monitoring Team did not support these improvements. A review of 26 of the Facility's completed monitoring tools for Acute Illness, and 58 completed monitoring tools for Injury and Urgent Care found that the Program Compliance Nurse had invested a great deal of effort in developing instructions for the tools, and had added some specific information next to a number of the items on the tools indicating she was conducting a	

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		detailed review. However, at the time of the review, the data generated from these tools had not been aggregated, thus it was difficult to determine overall compliance rates for each item on the tools. Thus, a review of the raw data from the tools found that the most of the problematic issues listed above by the reviewer were not being captured on the audits. To accurately audit Acute Illness and Injuries, the auditor needs to review the progress notes at least a few weeks prior to an admission to a community hospital, emergency room, or the Infirmary to determine when symptoms actually began to accurately assess the care provided. As noted after the last review, the auditor(s) for this area should read the "clinical story" first regarding acute illnesses and injuries keeping in mind that it might have been weeks prior to the hospitalization, emergency room visit, or Infirmary admission when the symptoms first started. Reading only selective notes at the time of the transfer does not provide an accurate assessment of compliance for changes in status from acute illnesses. Although the Program Compliance Nurse has completed over 600 nursing monitoring tools since the previous review, at this stage of the process, the number of audits completed should not be the focus. The Nursing Department needs to ensure that the quality of the treatment and care nurses are providing is being appropriately, and critically audited, and that the data generated is being aggregated and presented in a meaningful way to facilitate its interpretation. Although the Facility had identified some trends and issues based on the implementation of the monitoring tools, a number of other significant issues found during the past two reviews as well as the current review were not identified. From review of the Peer Review Meeting minutes, some of the issues noted from the Acute Illness and Injury and Urgent Care monitoring tools included: ▪ Documentation issues involving the Campus RNs; ▪ Seizure Records not being completed; ▪ Nurses not appropriately making new entries in the notes; ▪ Admission diagnosis not being addressed for Infirmary admissions; ▪ Legibility of the nurses' notes; ▪ Type of temperatures not being documented; and ▪ Health Management Plans not in records. Since the last review, the Facility had developed a draft of a policy addressing Responding to Acute Medical Problems, dated 12/22/10. Although the policy addressed a number of critical issues, the area addressing Nursing Responsibilities regarding documentation requirements should be as specific as those listed for the PCPs' responsibilities. In addition, the Facility had a draft policy from the State that addressed	

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		Management of Acute Illness and Injury, dated December 2010. Again, this draft policy addressed a number of critical issues. However, under the section addressing Procedure, the policy stated that: "the nurse will complete a focused assessment as soon as possible, but no later than one (1) hour." Allowing a one-hour timeframe for an assessment for an acute illness or injury without criteria addressing when this would and would not be appropriate could lead to serious delays in treatments. Although the Facility had obtained the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols, and the Health Care Protocols: A handbook for DD Nurses, the Facility had not individualized the procedures and protocols to address the Facility's structure and systems. Once this is appropriately completed, some of the procedures and protocols should be integrated and cross-referenced with the draft State and Facility policies so that specific responsibilities and appropriate timeframes are clearly outlined. As noted in the previous review and confirmed in this review, due to the number of medically compromised individuals who had been admitted to the hospital, seen in the emergency rooms, admitted to the Infirmary, and the significant reoccurring problematic issues, it is imperative that the Facility implement appropriate nursing protocols and procedures. The efforts and interventions that the Nursing Department had initiated addressing this area since the last review were extraordinary. Unfortunately, the fruits of those efforts were not yet visible during this review. However, with continued efforts, improvements should be evident by the next review. Although not a requirement of the Settlement Agreement, the Nursing Department had developed and implemented a policy addressing Educational Peer Review. As noted from the policy, the purpose of the peer review was "an organized effort whereby - practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers and focus on the identification of strengths and weakness of the Facility's nursing practices." This was in alignment with the American Nurses' Association's definition of peer review. This process will bring a professional review process to the Nursing Department, reinforce the self-assessment activities, and facilitate the department's forward movement toward compliance with the Settlement Agreement. <u>Availability of Pertinent Medical Records</u> At the time of the review, based on information provided by Medical Records staff at the entrance meeting, the Facility had completed transitioning all the medical records to the new format. Consistent with the last review, in reviewing some of the records onsite, it was noted that very few documents had to be obtained from the units compared to the baseline review. In addition, since the last review, the CNE reported that a database had	

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		been developed and implemented to track routinely scheduled lab work and appointments that enabled staff to determine when an individual was due for these routinely ordered procedures. Also, in response to the Monitoring Team's recommendation that the Facility develop and implement policies and procedures addressing the services and documentation requirements of Respiratory Therapy, the Facility developed and implemented the Respiratory Therapy-Nebulizer policy, dated 11/15/10, outlining the procedure and documentation requirements for staff, including Respiratory Therapists, providing nebulizer treatments. From discussions with some of the nursing staff and review of the Nursing Department meeting minutes, there had been some problematic issues concerning having timely access to bowel records so that nurses could review these to determine if individuals needed additional medications. At the time of the review, there had been no resolution of the issue. The Facility should ensure that all information relating to the medical/psychiatric needs of the individuals are easily and timely assessable to clinical staff. In addition, the Facility should continue to ensure that other documents such as lab work, diagnostics, and consults are filed in a timely manner in the individuals' records. The Facility had developed a draft policy entitled Filing, dated 11/4/10, indicating that: "the File Clerk or designee will file any received document that is designated as a priority document within one working day of its completion after checking to ensure that the responsible team member has reviewed the document prior to filing as needed." Although a very positive step in ensuring that documents are filed timely in the record, a number of issues such as how a document is designated as priority should be further outlined. In keeping with this issue, the Facility might want to consider developing and implementing a tracking system to ensure that all documents as noted above are timely returned to the Facility and timely filed in the records. <u>Infection Control</u> Since December 2010, the Facility no longer had an Infection Control Nurse. The Facility continued to have a full-time registered nurse as an Assistant Infection Control Nurse. On 6/1/10, she came to the department with no previous experience in infection control or public health. Her duties included assisting with the tracking of individuals' immunizations, PPDs, and vaccinations, as well as developing and maintaining a database for these items, which had been put in place. The Infection Control Nurse was responsible for developing systems for the program, and addressing infection control issues related to employee issues. At the time of the review, the Assistant Infection Control Nurse had been on leave for the month of December, and had just returned back to work during the review week. Thus,	

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		the Monitoring Team was only able to conduct a limited review based on the available documents and input from the CNE and NOO. From review of the Nursing Presentation Book and discussions with the Assistant Infection Control Nurse, the Infection Control Nurse had conducted additional competency-based training with the Assistant Infection Control Nurse regarding immunizations and Tuberculin Skin Tests (TSTs), during evenings and weekends, and had documented this training. In addition, the Assistant Infection Control Nurse had attended a one-day seminar regarding the topic of immunizations, and completed an online course addressing Tuberculosis. The Infection Control Nurse also observed her providing teaching to staff regarding isolation procedures. When the Facility fills the Infection Control Nurse position, the Assistant Infection Control Nurse should be provided continuing education and training focused on Infection Control issues to enhance her knowledge and ensure that Infection Control staff is clinically competent in this specialized area. Since the last review, the Facility developed appropriate job descriptions/job duties addressing the Assistant Infection Control Nurse position. From discussions with the CNE and the State Office Nursing Services Coordinator, the SSLC Infection Control Resource Manual was expected to be released within the month. The Facility should ensure that their Infection Control policies, procedures or protocols are modified addressing the integration of the Assistant Infection Control Nurse position. Although the Facility's Infection Control (IC) program had established a tracking system regarding the basic areas of surveillance for MRSA; Hepatitis A, B, and C; positive Tuberculin Skin Tests; HIV; Syphilis; current immunizations; current vaccines; and antibiotic use, it was apparent from the list provided at the time of the on-site review that the database had not been updated to reflect all of the relevant cases. Specifically, four individuals who recently had been diagnosed with MRSA and one individual found to have C-Diff were not included in the surveillance database. With the absence of both Infection Control Nurses, there was no system in place to ensure the surveillance list was kept updated and accurate. Since the Facility only had two positions for Infection Control, there should be a system developed and implemented to ensure that the functions and duties of these positions are delegated in the event the staff in these positions are unavailable. From review of the documentation and discussions with the CNE, there continued to be no formalized system in place to ensure the reliability of the Facility's IC data. As noted during previous reviews, without a system in place to determine the reliability of the infection control data, the Facility cannot accurately identify its trends or problematic changes in trends that require timely corrective interventions, ensure that treatments	

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		and treatment plans are clinically sound, ensure that timely and appropriate training is provided, or initiating proactive interventions from analyses of past data trends. During the previous review, the Infection Control Nurse identified a number of informal systems designed to capture any information that might not have reported by the units, such as review of laboratory data, physician orders for antibiotics from the pharmacy, and 24-hour Facility reports. Due to the clinical relevance and ramifications of this area of nursing practice, data reliability for infection control is crucial. The Facility should develop and implement a formal system to ensure data reliability regarding surveillance tracking for infection control. From previous reviews, it was reported that the activities of the IC program were documented in both the IC Committee Meeting minutes and in the Pharmacy and Therapeutics Committee Meeting minutes. Consistent with the findings from the last review, there was little indication from the Pharmacy and Therapeutic Committee meeting minutes that any infection control issues were being regularly discussed. It would be helpful to the Facility to have clearly defined areas that are to be addressed by each committee. The Facility should determine and formalize what specific areas will be addressed regarding infection control issues in the IC Committee meetings and in the Pharmacy and Therapeutics Committee to ensure all issues are being addressed. A review of the IC Committee Meeting minutes found that the format of the minutes had been modified to include the areas of: issues, facts, due dates, discussion, and responsible persons. In addition, a plan of correction was included in the minutes for problematic issues that were identified. The modifications organized the information so that issues were easily identified. In addition, the minutes included supplemental raw data and graphs related to IC issues. However, there was no comprehensive analysis regarding any trends that were shown in the data. For example, the data and graph clearly indicated that in August 2010, there had been an increase of MRSA in individuals the Facility served, and in March 2010, a significant increase in the episodes of pneumonias. However, there was no documentation found indicating that a comprehensive analysis was done regarding these trends, that inquires were made regarding the problematic trends, that corrective actions were implemented to address them, or that there was any monitoring of outcomes in relation to the activities and interventions of the Infection Control program in conjunction with the practices on the units. Consistent with the findings during the past reviews, the Facility was not aggressively investigating problematic trends identified in their own data regarding communicable disease and infectious processes. While the Monitoring Team was on site, on 1/3/11, the Facility reported that there had been an outbreak of scabies beginning on 12/8/10, and since that time a quarantine for Ribbon Fish had been implemented where additional cases had occurred. At this time,	

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		the Facility had not developed a timeline of events, but the Monitoring Team asked them to do so. Although the Facility promptly developed a comprehensive timeline, this should have been implemented sooner when the outbreak initially occurred. From discussions with the CNE and NOO, it was discovered that the first case of scabies was actually identified in November 2010. Because the incubation period for scabies is between two to six weeks, the cases identified in December most likely were due to the spread of the organism and not unrelated to the initial case. From interviews, observations, and review of records and timelines, the following problematic issues were identified: ▪ While trying to identify cause of the rash for the initial individual who was diagnosed with scabies, the individual was not proactively placed on contact precautions. ▪ There was no indication that the environment was ever appropriately treated to prevent the spread of scabies based on the initial case diagnosed in November, or for any of the cases that followed until the time the Monitoring Team was on-site. ▪ There was no indication that the other individuals in the home were proactively and regularly monitored for signs and symptoms of scabies after the initial occurrence. ▪ Although training rosters indicated that the staff were provided initial training regarding contact precautions, there was no indication that there was monitoring implemented to ensure that staff were appropriately and consistently implementing the procedures. ▪ As additional individuals were found to have suspicious skin rashes and/or itching, there was no indication that they were proactively placed on contact precautions until a diagnosis was determined. ▪ A review of the records of individuals diagnosed with scabies identified significant gaps in the nurses' documentation indicating that they were not regularly assessing the individuals. This also indicated that the nurses did not recognize that it is not uncommon for the initial treatment not to eradicate the symptoms and further treatments might be warranted. ▪ While the scabies outbreak was happening, there were three cases of MRSA and one case of C-Diff diagnosed in the Ribbon Fish residence. At the end of the Monitoring Team's review week, additional individuals were experiencing symptoms and being tested for C-Diff. ▪ When the Facility first reported the outbreak to the Monitoring Team, the Facility had not contacted the local Health Department or the State Office to validate the appropriateness of their interventions, and/or to seek additional advice on dealing with the outbreak. ▪ In response to the outbreak, the Facility hired a company to clean and sanitize	

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		the buildings. However, there was no validation the chemicals the company used actually would kill scabies. The Facility's timeline indicated that Safety Data Sheets were obtained after the company began their process. As is noted with regard to Section L.1, the chemicals used likely did not kill scabies. ▪ Despite the fact that a number of individuals at the Facility had respiratory risks, respiratory assessments were not initiated for the individuals exposed to the chemicals the cleaning company used until the Monitoring Team prompted it. ▪ As is discussed with regard to Section L.1, the Medical Director had not provided leadership in directing the Facility's activities in addressing the outbreak. ▪ The Facility's timeline indicated that they were running out of supplies for contact precautions, and could not get their supply company to ship the supplies overnight. Supplies had to be purchased from local medical supply store. ▪ The Assistant Infection Control Nurse returned to duty during the Monitoring Team's review week. From discussions with her, she had not been briefed on the outbreak, or informed of which individuals were diagnosed with scabies, MRSA, or C-Diff, and/or what actions had been taken thus far. She reported she had a number of emails and had not been able to read them to find out what the status of the outbreak was. There was no scheduled meeting for a face-to-face briefing on the situation, nor did one occur while the Monitoring Team was on site. ▪ A review of the Facility's policy regarding scabies found it to be inadequate. ▪ The Facility had scheduled meetings (e.g., PSP and quarterly review meetings) in Ribbon Fish after it was quarantined. Until prompted by the Monitoring Team, the Facility had planned to conduct these meetings in the building in spite of the quarantine. ▪ Likewise, the Facility indicated that direct support professionals had been instructed only to go to that building, and they were not being reassigned to other buildings. However, when the Monitoring Team asked, similar instructions had not been given to other staff, such as physicians, therapists, etc. Only after the Monitoring Team's inquiry regarding the extent of the "quarantine" were such instructions provided to ancillary staff. ▪ On the third day of the review, the CNE reported she had contact with the State's Nursing Services Coordinator and had received a copy of the guidelines for scabies. A review of the document indicated it was generic and not the institutional guideline for scabies. ▪ From November 2010 to January 2011, the Facility had not implemented any appropriate treatments for the environment. On January 5, 2011, the Facility began placing individuals' belongings and other articles in plastic bags to be isolated for 72 hours, which leaves the organism without a host and consequently it dies. ▪ By the end of the review week, the Facility's timeline indicated that 13	

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		individuals had been diagnosed with scabies and three staff members. Based on the delay in implementing contact precautions and adequately treating the environment and the two-to-six week incubation period for scabies, it would not be surprising if additional individuals and staff had contracted scabies for a number of weeks after the review. This situation clearly indicated there was a lack of leadership, competency, formal systems and communication lines, decision-making, and problem-solving in reviewing this situation. The significant systems failures noted highlighted the need for the Facility to have clinically competent staff in the area of infection control to ensure clinically sound practices regarding communicable and infectious diseases. Although scabies is not considered a life threatening issue, the distasteful reaction of every staff member who heard or talked about it should reflect how uncomfortable the individuals exposed to it likely were for an extended period of time. This was confounded by the mismanagement of the situation, which resulted in numerous individuals contracting the contagious condition, and placing numerous other individuals at risk. Given that the threat is very real that life threatening or life-altering infections could spread in the same manner if not managed properly, the Facility must ensure that staff who are working in the area of Infection Control are both clinically and administratively competent in this specially area. Information requested from the State's Nursing Services Coordinator did not adequately address how competency in infection control was determined. Clearly, the situation described above indicated that even in November when the first case manifested itself and the Facility had a full complement of infection control staff, there was a critical lack of clinical judgment regarding the appropriate procedures to implement to address a cases of scabies. Additional expertise in Infection Control is needed to assist the Facility in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.	
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.	In August 2010, the Facility initiated a new Educational Peer Review Tool to address some issues related to the Nursing Assessments. In addition in November 2010, the Facility revised the competency-based training regarding Nursing Assessments and provided training to the RN Case Managers and Nurse Managers. A review of the revised competency-based training curriculum for the Comprehensive Nursing Assessment found that the methodology had improved from the past curriculum. However, the examples of the Nursing Summaries provided in the Nursing Presentation Book did not accurately reflect an adequate nursing analysis and consequently did not reflect adequate competency-based training for Nursing Assessments.	Noncompliance

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		There continued to be problems regarding the analysis of quarterly data as compared to the past quarter's data. When conducting a nursing analysis, the nursing staff should ask the same questions for each health/mental health issue the individuals' experience: "is the individual doing better, worse, or maintaining from the previous quarter or year and why?" The "why" forces the nurse to review the effectiveness of the Nursing Care Plan interventions; address noncompliance issues; review physician's orders; review the effectiveness of the other disciplines interventions; review the nursing progress notes, physician notes, and direct support professionals' notes for unidentified trends; review lab work results, diagnostic testing results, and recommendations from consultants; and review other documents that might contribute to answering the "why" question. It is imperative that the Facility develop an appropriate competency-based training curriculum in this area. The competency-based training for the Comprehensive Nursing Assessment should be revised to measure adequately nurses' competency in producing a quality comprehensive nursing assessment. The records of 65 individuals were reviewed, including: Individual #255, Individual #186, Individual #218, Individual #114, Individual #109, Individual #158, Individual #88, Individual #323, Individual #203, Individual #95, Individual #231, Individual #41, Individual #6, Individual #318, Individual #267, Individual #302, Individual #242, Individual #174, Individual #92, Individual #62, Individual #193, Individual #359, Individual #53, Individual #94, Individual #151, Individual #277, Individual #237, Individual #246, Individual #325, Individual #30, Individual #295, Individual #238, Individual #342, Individual #161, Individual #43, Individual #324, Individual #245, Individual #68, Individual #101, Individual #366, Individual #36, Individual #37, Individual #350, Individual #28, Individual #319, Individual #236, Individual #146, Individual #50, Individual #290, Individual #334, Individual #222, Individual #195, Individual #181, Individual #240, Individual #299, Individual #252, Individual #24, Individual #163, Individual #145, Individual #137, Individual #89, Individual #150, Individual #291, Individual #67, and Individual #270. A review of the quarterly and/or annual nursing assessments completed since November 2010 found that all of the individuals (100%) had their nursing assessments timely completed. However, consistent with the findings from the September 2010 review and the baseline review, the quality of all 65 individuals' assessments was extremely poor. In particular, the summary narrative section for all of the 65 individuals' assessments reviewed did not include an analysis of the individuals' health status and contained either only raw data or statements, such as about diet changes, without the rationale for the change with an analysis of the effectiveness of the change or the clinical outcome of the health issues. From discussions with the Chief Nurse Executive, nurses were being trained to use the Heath Managements Plans (HMPs) to structure the summary section of the nursing assessments. Although this was a reasonable idea, the assessments reviewed that used the HMPs to structure the summaries did not include an analysis of the health or	

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		behavior data between the previous and current quarters. These assessments included only a list of the interventions that were contained in the HMPs. For example: ▪ The Annual Nursing Assessment, dated 11/12/10, for Individual #255 indicated that he had received a prescription for glasses, which he had been refusing to wear. He also had refused to attend his Ears, Nose, and Throat (ENT) appointment. In addition, he had an abnormally high prolactin level, an abnormal echocardiogram, and unstable blood sugars. He weight was 262 pounds, and his Body Mass Index (BMI) was 36.6, indicating obesity. The nursing assessment noted that he had gained 36 pounds in the past year and had elevated triglycerides. The documentation in the section entitled Nursing Diagnosis, which reflected what nursing care plans were in place, indicated the following: o Generalized anxiety disorder; o Major Depressive Disorder; o Pedophilia; o Nicotine dependence; o Insomnia; o Diabetes Mellitus; o Obesity; o Moderate cataracts; and o Hearing loss. The Nursing Summary stated: "Client had numerous client to client and self injurious behaviors. Seems to have resolved during the last psych drug change. Besides client to client altercations and numerous SIBs client has been in good health this last year. There have been no major health concerns other than non-compliance with the diet leading to elevated glucose levels and higher than desired lipid levels." The assessment included no status of the Nursing Diagnoses, or any analysis of the health and behavioral issues from the past year. The lack of an appropriate clinical nursing assessment and analysis indicated that nursing staff, as well as the rest of his team were not addressing his health risks and the changes in his health indicators, placing him at serious risk. This annual nursing assessment was dramatically inadequate. ▪ In another example, the Quarterly Nursing Assessment, dated 12/29/10, for Individual #6 indicated that he had poor oral hygiene and needed multiple restorations. He recently had been prescribed medication for seasonal allergies and had received treatment for a sore on his right leg. The	

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		assessment noted that a HMP was initiated for pain related to osteoarthritis. The section entitled Nursing Diagnosis, which reflected what nursing care plans were in place was left blank. His nursing quarterly summary stated: "Client was medically stable during this quarter. He remains on a care plan for pain and has been controlled. No new recommendations. Nursing will continue to monitor any new issues as they arise." Again, the assessment included no analysis of the individual's health issues listed throughout the assessment, and concluded with a superficial summary that appeared inaccurate and lacked specific details. The assessment provided no information about the individual's current status as compared to his status last quarter. ▪ The Nursing Quarterly Summary for Individual #318, dated 12/23/10, indicated that he was seen for his Annual Psychiatric Evaluation and had an emergency dental exam. However, no specific information was included about either appointment. In addition, his lotion for athletics foot was discontinued due to his refusing the medication for the past month. Also, the assessment indicated that he had gained 12 pounds in the last quarter and currently weighed 256 pounds with a BMI of 29.7, placing him in the obese range. His bedtime snack was discontinued to promote weight loss. It also was noted that he had three fractures in the past that included his right elbow, nasal bone, and his left index finger. The assessment indicated that he had a seizure disorder with his last seizure being on 7/11/10, and that he had experienced falls and had vision impairments, but no specific details were included in the assessment. The documentation in the section entitled Nursing Diagnosis stated: "no care plans initiated." His nursing quarterly summary stated: "Client remained medically stable during this quarter. No further recommendations. Nursing will continue to monitor and address issues as they arise." The information the State's Nursing Services Coordinator provided regarding the State's plan for enhancing the Facilities competency-based training for nursing assessments and care planning indicated that currently, the Nurse Educators provided the competency-based training regarding nursing skills and care planning. In addition to this, the State was planning to purchase materials including the Mosby/Elsevier Nursing Diagnosis Handbook, Eight Edition, as a competency-based nursing assessment course. The materials included in this package were textbooks, lab manuals, and online resources. Nurse Educators, Case Managers, RN IIs and RN IIIs would be required to participate in the training. The RNs would complete the course under the supervision of the Nurse Educators with the Nursing Services Coordinators and the Nurse Practitioner Consultant	

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		providing oversight. In addition to the course work, and the competency- based skills check off the Nurse Educators already were using, nurses or advanced practice nurses with expertise in clinical assessment would randomly select and evaluate Facility nurses on their nursing assessment and care planning skills. The State proposed this program to improve nursing care and encourage critical thinking during assessments and in developing care plans. Although resources such as the materials in the Mosby/Elsevier Nursing Diagnosis Handbook, Eight Edition, are valuable to skill building, the proposed competency-based training process raised a number of concerns including: ▪ The current competency-based training for nursing skills the Facility provided was inadequate. For example, the competency-based training for lung sounds only consisted of listening to a CD of the different types of abnormal sounds without requiring nurses to demonstrate a supervised assessment on an individual. As a result, there was no validation that the nurse could accurately identify the lobes of the lungs or the sounds heard during the assessment. Thus, the training that already was in place at the Facility was not adequately identifying nurses who were or were not able to demonstrate this crucial skill. This was particularly problematic for a Facility supporting a high number of individuals with respiratory risk factors. From a review of the records of a number of individuals who had acute respiratory issues, most of the nurses' notes contained no assessment of lung sounds while others contained statements such as "lung sound abnormal." The latter indicated that although nurses heard something during the assessment that caused concern, they were not able to identify what they heard or where they heard it, or did not recognize the importance of documenting their specific findings. A dramatic example of this issue was seen during medication administration while the Monitoring Team was on site. When a nurse was attempting to listen to an individual's lung sounds, the individual began coughing after receiving their medication via gastrostomy tube (G-Tube). However, the nurse was unfamiliar with the location of the lobes of the lungs to adequately conduct an assessment. This example illustrated a clear deficit in competency for this skill. ▪ In the State's proposal, the competency of the staff overseeing the course work was assumed. The examples noted above and the continued lack of adequate competency- based training curriculum regarding the quarterly and annual Nursing Assessments and, the Care Plans challenges this assumption. ▪ The proposed competency-based training did not include a "hands on" component for each nurse who was required to demonstrate competency in the identified areas. Although for Quality Assurance purposes randomly selecting nurses to evaluate the effectiveness of the training would be	

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		appropriate, this is not adequate from the day-to-day practice perspective, particularly because such major deficits have been identified. It would stand to reason that nurses and/or advanced practice nurses with clinical expertise in assessments should play a major role in the initial determination of competency for the nurses participating in the course work training. ▪ Textbooks provide a resource to the Facility for nurses to refer back to when they need a refresher regarding specific information. The significant problematic issues found in the nursing practices at CCSSLC during the past two reviews as well as the current review indicated that the purchases of the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols, and the Health Care Protocols: A handbook for DD Nurses did not improve nursing care in any area reviewed. Based on this finding, it is troubling that the State's plan to address the critical deficits in nursing competency consists of the purchasing of another textbook with little to supplement it. From a professional perspective, competency and expertise develops from mentoring, consistent practice, and the practical use of the desired skill set. Thus far, the use of textbooks as initial solutions to problematic areas had not proven effective. The State should invest its resources in strategies that include more "hands on" interventions at the Facility level, and then assess the need for obtaining additional expensive resource materials. At CCSSLC, a good example of a hands-on approach that appeared to be resulting in positive improvement in nurses' clinical skills was when the Nurse Educators implemented the practice of routinely visiting residences and randomly asking nurses to demonstrate the emergency equipment and discuss the equipment used for the different oxygen flow rates. This type of "hands on" mentoring brings the teaching directly to the nurses in their work environment through one-on-one individual contact. In addition, the State indicated that in January 2011, the SSLC Nurse Educator Workgroup would be meeting to finalize the SSLC Nurse Education Handbook, which will standardize competency-based training throughout all Facilities. This is a positive step forward. However, the State in conjunction with the Workgroup needs to ensure that the actual process of assessing competency is appropriate and adequate. Consistent with the past two reviews as well as the current review, the lack of a clinical assessment of critical health indicators, the lack of follow up on unresolved issues, the lack of an analysis of obvious clinical risks, and the lack of clinical and critical thinking was found in all 60 nursing assessments reviewed.	

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M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	From discussion with the Chief Nurse Executive and the Facility's POI, the Facility reported that in October 2010, they had reviewed individuals' Axis Diagnoses along with the active problem list to identify individuals who needed to have Nursing Care Plans [Health Management Plans (HMPs)] put in place to address health and behavioral issues. In December 2010, the POI indicated that HMPs were initiated for individuals who were identified as having health risks related to the areas listed below. The health indicators that were identified as not being addressed in the current HMPs were prioritized and the Facility concentrated on initiating HMPs for the following areas: • Psychotropic Medication; • Seizures; • Bowel Management; • Infection Control issues; • Diabetes; • GERD; • Urinary Tract Infections; • Respiratory Health; • Pain; and • Hypertension. A review of 130 HMPs, including a number of HMPs from each of the categories listed above, found none (0%) to be adequate. All the HMPs reviewed were found to be basic templates with little to no individualization. In addition, on 10/15/10, the Facility brought in an RN consultant from a local college who provided a 30-minute overview on Nursing Care Plans. Since the last review, there had been some additional competency-based training provided regarding the Health Management Plans that appeared to be the same curriculum as previously used; a fictitious person had a urinary tract infection (UTI) with an elevated white blood count (WBC), which indicated an infection. The nurse being trained then developed a HMP addressing this issue. A review of the HMPs generated from the training found the same problematic issues as noted during the last review which included: ▪ The goal the nurses listed on all the competency tests was that the individual would have a white blood count within normal range. An appropriate nursing goal for this issue would be related to the prevention of additional urinary tract infections targeting the etiology or risk factors that could have precipitated the current urinary tract infection such as low fluid intake, tendency not to void when feeling the urge, or inappropriate hygiene care. The white blood count was an objective indicator by which to measure how successful nursing was in meeting a goal addressing the prevention of further UTIs.	Noncompliance

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		▪ The interventions found on the competency tests addressing urinary tract infections were built around the template's listed interventions and not the specific needs of an individual. The records of 39 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #154, Individual #273, Individual #304, Individual #266, and Individual #128 for Osteoporosis; Individual #131, Individual #311, Individual #153, Individual #240, Individual #325, Individual #117, and Individual #2 for Aspiration; Individual #31, Individual #19, Individual #294, Individual #356, Individual #202, and Individual #181 for seizures; Individual #174, Individual #62, Individual #109, Individual #336, and Individual #315 for weight issues; Individual #228, Individual #103, and Individual # 223 for impaction; Individual #278, Individual #207, Individual #375 and Individual #357 for skin issues; Individual #101, Individual #76, Individual #79, Individual #9, Individual #51, and Individual #32 for Gastro esophageal Reflux; Individual #263, Individual #86, and Individual #42 for falls. Of the 39 Individuals' HMPs reviewed: ▪ Thirty-four (87%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have an HMP all were identified as being high risk for Osteoporosis and included: Individual #154, Individual #266, Individual #304, Individual #273, and Individual #154. ▪ None (0%) of the nursing interventions contained in the HMPs 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. ▪ None (0%) of the HMPs were found to be clinically adequate. Consistent with the findings from the previous reviews, the lack of individual-specific interventions based on the individuals' needs provided little to no direction for caring for individuals who were identified as being at high risk, and for measuring individuals' progress toward their goals. In addition, consistent with the previous review's findings, the interventions contained in the nursing care plans were not geared toward prevention or minimizing health risks. For example: ▪ Individual #103 was identified as high risk for impaction. Her HMP for this issue stated: "Staff will record all BMs (bowel movements) accurately and LVN will check BM record daily. LVN will ensure the laxatives/bowel preparations are given as ordered. LVN will follow bowel protocol as follows: on the a.m. of the 2nd day of no BM, prune juice will be given, on the 3rd day of no BM, Milk of Magnesia and prune juice will be given, and on the 4th day of no BM, an enema will be given following a full bowel	

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		assessment; if no results after the 4th day, RN/MD will be notified." This HMP included no interventions addressing preventing episodes of constipation, such as ensuring adequate fluid intake or a diet high in fiber, or increasing activities that include movement and ambulation. In addition, waiting for four days before conducting an assessment, which should include evaluating bowel sounds and palpation of the abdomen, on an individual who is not responding to treatments for constipation is clinically inappropriate. Consequently, the HMP indicated that only time nursing was to provide care was when the individual was experiencing constipation. In addition, a sample of 10 individuals who were identified at being at high risk using the Facility's new High Risk System were reviewed to determine if these individuals had appropriate nursing care plans addressing their high risk health issues including: Individual #146, and Individual #101 for cardiac; Individual #70 for seizures; Individual #255, and Individual #186 for weight issues; Individual #298, Individual #177, Individual #230, Individual #20, and Individual #312 for psychiatric issues. Of the 10 Individuals' records reviewed: ▪ Nine (90%) had a HMP addressing their high-risk health/mental health indicator. The individual who did not have a HMP was Individual #101 ▪ None (0%) of the nursing interventions contained in the HMPs 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. ▪ None (0%) of the HMPs were found to be clinically adequate. Clearly, the Facility was continuing to struggle with developing adequate and individualized HMPs while trying to work within confines of the nursing protocols that had been adopted as templates for HMPs. The HMPs need to reflect the actions nurses are engaged in for prevention, health maintenance, and health promotion. In order to attain the goal of quality Health Management Plans, the Health Care Protocols should be modified to include appropriate goals and should be significantly individualized. Consistent with the findings during the previous review, the competency-based training for the Health Management Plans should be revised to adequately measure nurses' competency in producing a quality care plan. In addition, collaboration with other disciplines regarding care plans should occur regardless of the format, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all health management plans as required by Sections G and F of the Settlement Agreement. Consideration should be given to the use of an integrated health management plan that would incorporate all clinical disciplines goals and	

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		interventions into one plan.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Since the last review, the Facility had obtained the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols. However, there had been no modifications made to the procedures and protocols contained in the text of these resource books to bring them into alignment with the Facility's structure and systems. For example, such modifications would need to include the specific responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, and the timely reporting of symptoms to the practitioner/physician. Since the last review, the State had completed a draft Nursing Protocol addressing Seizure Management, dated December 2010. A review of the draft protocol found that it was thorough and comprehensive with clear parameters for documentation requirements and notification of the practitioner/physician. In addition, the responsibilities for each discipline were clearly outlined. This was a good example of modifying standard nursing practice to define the expectations within the context of the Facility. Once this protocol is approved, the Facility should implement training of the protocol. As mentioned with regard to Section M.1, the Facility had developed a draft policy addressing Responding to Acute Medical Problems, dated 12/22/10, and the State had drafted a policy addressing the Management of Acute Illness and Injury, dated December 2010. As also discussed with regard to Section M.1, although both policies needed further revision, no Facility specific procedures and protocols had been integrated and cross-referenced with these polices ensuring that responsibilities and appropriate timeframes were clearly outlined for various health issues. At the time of the review, the Facility did not have a plan for when the procedures and protocols would be modified and implemented. The consistent negative findings described with regard to Section M.1 related to assessment and documentation of individuals with acute changes in status highlighted the urgent need for this requirement of the Settlement Agreement to be addressed promptly and adequately. The Facility should make the appropriate modifications to the procedures and protocols contained in the resource textbooks to reflect with the Facility's structure and systems, including defining the specific responsibilities of disciplines, and setting forth clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, and the parameters for the timely reporting of symptoms to the practitioner/physician. As is discussed in detail above with regard to Sections M.2 and M.3 of the Settlement Agreement, the Facility continued not to have an adequate assessment process in place, with written parameters for notification of the practitioner/physician, nor did it develop	Noncompliance

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		adequate health management plans. Consistent with the previous two reviews and the current review, the Facility was failing to adequately and timely address the health care needs of the individuals at CCSSLC.	
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.	Since the last review, the State and the SSLCs had developed a policy for At-Risk Individuals, dated 11/2/10. The policy included Risk Guidelines, which contained criteria to assist the teams in determining risk levels for a number of risk factors. In addition, the assignment and review of risks was to be conducted during the PST meetings, and the Health Status Teams would no longer exist. The Facility reported that all individuals would have their risk assessments and risk rating completed at their regularly scheduled quarterly PST between January 1, 2011 and March 31, 2011. The new policy indicated that nursing in conjunction with the PCP was responsible for assessing risk factors in the following categories: ▪ Aspiration; ▪ Respiratory Compromise; ▪ Cardiac Disease; ▪ Constipation/Bowel Obstruction; ▪ Diabetes; ▪ Gastrointestinal Problems; ▪ Osteoporosis; ▪ Seizures; ▪ Skin Integrity; ▪ Infections; ▪ Fractures; ▪ Fluid Imbalance; ▪ Hypothermia; ▪ Urinary Tract Infections; and ▪ Circulatory. At the time of the review, the Facility had just begun the implementation process of the new At-Risk Individuals policy. It was not clear if all staff had received training on the new policy and the use of the Risk Guidelines. From observations of a PST Meeting for Individual #338 on 1/6/11, the nurse presented information to the team, including that the individual had a history of an ankle fracture, was on medication for osteoporosis, and had four falls in the past year. Of note, the nurse did not provide the Dexa Scan score. In spite of this information, the nurse assigned the individual at low risk for osteoporosis, and a low risk for fractures. In addition, the individual was reported to be on a regular medication regimen for constipation, and had required eight additional PRNs to aid with bowel function. Also, one of the PST members indicated that the individual was taking a supplement that could cause constipation. The	Noncompliance

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		individual was assigned a low risk level for constipation. There was little discussion from the team regarding these risk levels, and there was no input from the individual's physician regarding the assigned risk levels. In fact, the physician was not seated at the table with the team, the individual, or her family members, but sat against the wall, and provided little input. Although the At-Risk Individuals policy was just recently implemented, the findings of the past reviews and the current review indicated that there was a significant lack of clinical judgment used in identifying risk levels, especially from the Nursing Department. This will threaten the integrity of the Risk Process, and continue to result in the inappropriate identification of clinical risks and the assignment of risk levels. The Risk System is the essential foundation that identifies those individuals who warrant the most clinical intensity. Many examples have been provided throughout the findings in Section M.1, M.2, and M.3 of the continued consistent misidentification of individuals who were at risk. The Facility has to address the clinical competency issues in nursing in order for this system, as well as other health care systems to be successful.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the previous review, the Nursing Department had continued to implement a number of interventions addressing the medication administration system. The Medication Administration meeting had been merged with the Medication Error Committee due to the lack of LVN's being able to attend. The Medication Observation tool was again revised to include an item prompting a review of the Emergency Checklist in the residence. This was done to ensure it was being filled out daily indicating that staff were checking the operations of the emergency equipment. This was a positive addition since a review of the Emergency Cart Checklists from August 2010 through January 2011 found that there were a number of blanks indicating that the emergency equipment was not being checked daily as required. Also, in addition to increasing the frequency of the medication observations for nurses, which was implemented during the last review period, Nursing Education initiated spot checks of the Medication Administration Records to review for pre-signing, post-signing and MAR blanks. The data the Nurse Educator kept indicated a dramatic decrease in the number of MAR blanks since the initiation of the spot checks, from 262 to 197, which is another positive step for the Facility's medication administration system. In addition, the Facility had developed a database for the Medication Observations in order to aggregate the data generated from the observations and begin to identify any trends. A review of Medication Passes Assessment Tools verified that 88 nurses had been observed sine the last review. Some of the initial trends the Facility identified for	Noncompliance

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		25 medication observations in October 2010 included the following: ▪ Eight percent of the nurses were not aware of the fluid texture the individuals were required to have. ▪ Twenty percent of the nurses did not give the medications in the required timeframe. ▪ Twelve percent of the nurses did not sign the MAR immediately after administering the medications. ▪ Twelve percent of the nurses did not ensure that the individual swallowed the medications administered. ▪ Four percent of the nurses did not instruct the direct support professionals to keep the individuals upright after medication administration. Although the database and trend analysis was recently initiated, it appeared to have a great deal of potential in assisting the Facility in identifying medication administration trends. The Facility should continue to utilize the Medication Observation database to analyze its trends regarding medication administration, and to generate plans of correction addressing problematic trends, which it had not yet done. Although the Facility reported it had established inter-rater reliability, the established percentage was not reported. As mentioned previously, the Facility should develop and implement a procedure for establishing inter-rater reliability so that all disciplines are using the same procedure. A review of the Medication Administration Workgroup meeting minutes provided minimal information regarding what the committee was addressing during the meetings. In fact, the minutes for June, July, and August 2010 were basically identical. For the few issues identified in the minutes, there was no indication of an analysis of the issue, interventions implemented to address the issues, or any follow up that was conducted noting the outcome. The Facility should modify the format of these minutes to clarify the issues and actions of the committee by including items such as: issue discussed; plan of correction, including person responsible, and target date for implementation; actual date of implementation; and outcome and/or follow-up. In addition, a review of the Medication Error Committee meetings indicated that the committee only met three times since the last review. Two meeting were canceled due to a lack of quorum and one was canceled due to a storm. Although the committee had not been meeting consistently, the minutes from the meetings that did take place indicated a plan of action was initiated for issues identified so that the committee would be able to follow up and track the implementation of action steps and outcomes. The Facility should consider using the same format as the Medication Error Committee meeting	

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		minutes dated 10/15/10, for the Medication Administration Workgroup meeting minutes. Some of the issues addressed in the Medication Error Committee meetings included: ▪ The efficiency of the Medication Administration Workgroup needed to be reviewed; ▪ The type of distractions during medication administration needed to be identified; ▪ The MARs needed a place for the signature of the witness for Insulin; ▪ Medications that should be administered before meals were not consistently timely administered; and ▪ Discrepancies were found on some of the Narcotic Sheets. Although the minutes indicated that these issues were discussed, there was only one meeting where there was a brief mention of the medication errors for the month. However, there was no analysis of the medication errors, including any identified trends. In addition, a review of the Pharmacy and Therapeutics Committee minutes found that the only mention of medication errors was on 10/22/10, noting that there had been an increase in transcription errors. Neither committee appeared to be reviewing and analyzing the Facility's medication errors. The Facility should develop a system to analyze medication errors for trends and patterns in order to develop plans of correction addressing the identified trends. When observing medication administration while on site for individuals living at Sand Dollar, the following significant issues were identified, all of which placed the individuals involved at risk. Specifically, the nurse did not: ▪ Ensure the individual was in the proper positioning prior to medication administration; ▪ Know the health risks of the individuals to whom she was administering medications; ▪ Use the PNMP to ensure individuals were in the appropriate positions; ▪ Correctly identify how to check for placement of a G-Tube; ▪ Describe correctly what she should hear when checking the placement of a G-tube; ▪ Assess an individual who began coughing until prompted; and ▪ Know how to accurately assess lung sounds. The Nurse Educator conducted many of the medication administration observation audits with the member of the Monitoring Team. For most issues, the Nurse Educator provided appropriate prompting and feedback to the staff nurse who was being observed. However, she did not provide instruction regarding assessing lung sounds,	

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		when the staff nurse clearly was not conducting an appropriate assessment, and only did so when the Monitoring Team recommended the individual have an appropriate assessment of his lung sounds. A review of the medication variance data the Facility provided found that data was only reported for the months of September, October, and November 2010. There was no explanation regarding the data for the months of June, July, and August 2010. The available data indicated the following; ▪ September: 5 reported variances 262 procedural variances ▪ October: 5 reported variances 197 procedural variances ▪ November: 4 reported variances 129 procedural variances As noted in the previous review, given a facility of CCSSLC's size and the number of medications given each day, as well as the data collected by the Facility through its medication administration auditing process, these data indicated a continued significant issue of underreporting of medication variances. The Facility should continue its efforts to accurately identify medication variances.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should ensure that all newly created nursing positions are integrated into the Facility's policies, procedures, and/or protocols.
2. Although the nursing staffing had remained stable, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement.
3. The Facility should develop and implement a procedure addressing the process of establishing inter-rater reliability so that all disciplines understand the process and execute it consistently.
4. As the Quality Assurance Committee – Nursing Committee refines its process, it should establish a percentage of the recommendations generated from the corrective action plans and validate that the recommendations are in fact being timely and appropriately implemented.
5. The Facility should develop and implement a unified system to present the data from the monitoring tools so that the data can be easily analyzed and trends identified. A unified system will also allow data to be easily reviewed and interpreted between disciplines and departments.
6. The QE Nurse, Program Compliance Nurse, and the Nursing Department should continue to ensure they are critically auditing clinical issues, and focusing on the quality of the nursing services provided and not the just completion of required documentation.
7. The Facility should focus aggressively on strategies that will address the significant lack of nursing clinical judgment that is pervasive throughout the Facility.
8. Due to the number of medically compromised individuals who had been admitted to the hospital, seen in the emergency rooms, admitted to the Infirmary, and the significant reoccurring problematic issues found, it is imperative that appropriate nursing protocols and procedures be implemented promptly.
9. The Facility should ensure that all information relating to the medical/psychiatric needs of the individuals is easily and timely accessible to clinical staff.
10. The Facility should continue to ensure that documents such as lab work, diagnostics, and consultations are filed in a timely manner in the

individuals' records.

11. When the Facility fills the Infection Control Nurse position, the Assistant Infection Control Nurse should be provided continuing education and training focused on Infection Control issues to enhance her knowledge and ensure that Infection Control staff is clinically competent in this specialized area.
12. The Facility should modify their Infection Control policies, procedures, and/or protocols to address the integration of the Assistant Infection Control Nurse position.
13. Since the Facility had only two positions for Infection Control, there should be a system developed and implemented to ensure that the functions and duties of these positions are delegated in the event the staff in these positions are unavailable.
14. The Facility should develop and implement a formal system to ensure data reliability regarding surveillance tracking for infection control.
15. The Facility needs to determine and formalize what specific areas will be addressed regarding infection control issues in the IC Committee meetings and in the Pharmacy and Therapeutics Committee to ensure all necessary issues are being addressed.
16. Given that the threat is very real that life threatening or life-altering infections could spread quickly if not managed properly, the Facility must ensure that staff who are working in the area of Infection Control are both clinically and administratively competent in this specially area.
17. Additional expertise in Infection Control is needed to assist the Facility in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.
18. The competency-based training for the Comprehensive Nursing Assessment should be revised to adequately measure nurses' competency in producing a quality comprehensive nursing assessment.
19. State should invest its resources in strategies that include more "hands on" interventions at the Facility level, and then assess the need for obtaining expensive resource materials.
20. The Facility, in conjunction with the State and the Nursing Workgroups, should ensure that the actual process of assessing competency in nursing skills is appropriate and adequate.
21. In order to attain the goal of quality Health Management Plans, the Health Care Protocols should be modified to include appropriate goals and should be significantly individualized.
22. The competency-based training for the Health Management Plans should be revised to adequately measure nurses' competency in producing a quality care plan.
23. Once the Seizure Management protocol is approved, the Facility should implement training of the protocol.
24. The Facility should make the appropriate modifications to the procedures and protocols contained in the resource textbooks to reflect with the Facility's structure and systems, including defining the specific responsibilities of disciplines, and setting forth clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, and the parameters for the timely reporting of symptoms to the practitioner/physician
25. The Facility should continue to utilize the Medication Observation database to analyze trends regarding medication administration, and to generate plans of corrections addressing problematic trends.
26. The Facility should consider using the same format as the Medication Error Committee meeting minutes for the Medication Administration Workgroup meeting minutes, including items such as: issue discussed; plan of correction, including person responsible, and target date for implementation; actual date of implementation; and outcome and/or follow-up.
27. The Facility should develop a system to analyze medication errors for trends and patterns in order to develop plans of correction addressing the identified trends.
28. The Facility should continue its efforts to accurately identify medication variances.

The following are offered as additional suggestions to the State and Facility:

1. The Facility might want to consider developing and implementing a tracking system to ensure that all documents, such as lab work, diagnostics, and consultations, are timely returned to the Facility and timely filed in the records.

2. Consideration should be given to the use of an integrated health management plan that would incorporate all clinical disciplines goals and interventions into one plan.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Policy - Pharmacy Services and Safe Medication Practices N.9: Notification of a prescriber regarding potential unexpected or undesired outcomes with addition of a new medication in combination with existing medication regimen including supporting documentation, revised 12/30/10; o Patient interventions Facility CCS –from 7/1/10 through 12/31/10; o Individual orders with pharmacy comments on orders for: Individual #350 dated 12/8/10, Individual #34 dated 10/25/10, Individual #38 dated 10/25/10, Individual #46 dated 11/5/10, and Individual #104 dated 11/5/10; o Form: Allergy/ADR [Adverse Drug Reaction] reporting form for individuals discharged from hospital; o CCSSLC Restraints - monthly trend report per month from July to November 2010; o Protocol for checking allergies when entering pharmacy orders; o CCSSLC Restraints – quarterly trending report, from 9/1/10 to 11/30/10; o Chemical restraint use, from 8/10 to 10/10; o Individuals Restrained with Chemical Restraint During Time Period between 7/1/10 and 1/3/11; o Quarterly Drug Regimen Reviews (QDRRs) for the following individuals: Individual #372 dated 8/25/10, Individual #154 dated 8/13/10, Individual #104 dated 8/20/10, Individual #313 dated 9/27/10, Individual #344 dated 8/26/10, Individual #289 dated 7/28/10, Individual #134 dated 8/20/10, Individual #130 dated 12/16/10, Individual #38 dated 11/2/10, Individual #285 dated 11/9/10, Individual #343 dated 11/1/10, Individual #31 dated 11/17/10, Individual #79 dated 11/23/10, Individual #126 dated 11/12/10, Individual #161 dated 11/12/10, Individual #223 dated 11/10/10, Individual #180 dated 8/13/10, Individual #132 dated 11/1/10, Individual #372 dated 11/1/10, Individual #200 dated 11/10/10, Individual #19 dated 11/10/10, Individual #205 dated 11/19/10, Individual #344 dated 11/1/10, Individual #151 dated 11/10/10, Individual #369 dated 11/1/10, Individual #206 dated 11/4/10, Individual #294 dated 11/1/10, Individual #326 dated 11/1/10, Individual #282 dated 11/9/10, Individual #175 dated 11/17/10, Individual #18 dated 11/4/10, Individual #371 dated 11/1/10, Individual #250 dated 11/17/10, Individual #211 dated 11/9/10, Individual #50 dated 11/17/10, Individual #113 dated 11/17/10, Individual #163 dated 11/15/10, Individual #328 dated 11/15/10, Individual #34 dated 11/9/10, and Individual #324 dated 11/30/10; o Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint for the following: Individual #7, date of restraint 9/28/10; Individual #95, date of restraint 9/22/10; Individual #297, date of restraint 9/20/10; Individual #246, date of restraint 10/7/10; Individual #133, date of restraint 11/29/10; Individual #268, date of restraint 10/5/10; Individual #75, date of restraint 8/6/10;

		Individual #75, date of restraint 8/11/10; Individual #118, date of restraint 9/2/10; Individual #118, date of restraint 9/7/10; Individual #118, date of restraint 9/11/10; Individual #118, date of restraint 9/20/10; Individual #7, date of restraint 8/8/10; and Individual #357, date of restraint 8/11/10. o CCSSLC Pharmacy Services and Safe Medication Practices N.7: Drug Utilization Evaluation Policy, implemented 11/3/10; o Drug Utilization Evaluation (DUE) report for Olanzapine, dated 10/1/10 to 12/31/10; o Drug Utilization Evaluation Data Collection Form - Drug Audited: Zyprexa (Olanzapine); o CCSSLC Pharmacy Services and Safe Medication Practices N.6: Adverse Drug Reaction Policy, developed 11/12/10; o Adverse Drug Reaction Reporting Form; o Medwatch form, completed 11/9/10; o CCSSLC Pharmacy Services and Safe Medication Practices N.1: Quarterly Drug Regimen Review, draft/revision 9/2/10; o Quarterly Medication Review Worksheet; o CCSSLC Monthly Psychiatric Services Review (PSR) Minutes, Originally 8/27/10, rescheduled for 9/24/10; and Originally 10/22/10, rescheduled for 11/19/10; o Medication Errors 12 month summary (by quarters); o Medication Errors 12 month summary procedural errors (by quarters); o Medication Errors September 2009 to August 2010, September to November 2010; o Medication Passes Assessment Tool; o Medication Error Report, 8/10 to 12/10; o Medication Committee meeting minutes, dated 11/30/10, and 12/20/10; o Medication Error Committee meeting minutes, dated 6/24/10, 7/22/10, 8/6/10, 9/16/10, and 10/15/10; o Medication Administration Workgroup minutes, dated 9/24/10; o Pharmacy and Therapeutics Committee minutes, dated 10/22/10 and 12/14/10; o Department of Health and Human Services, Centers for Medicare and Medicaid Services, CCSSLC survey, completed 9/3/10, summary statement of deficiencies, provider's plan of correction; o Pharmacy plan of improvement/plan of action; o Texas health monitoring instrument - pharmacy services; o DISCUS evaluations for: Individual #176, DISCUS date of exam 12/3/10, prescriber review date 12/7/10, last exam date 11/30/10; Individual #2, DISCUS date of exam 10/25/10, prescriber review date 10/26/10, last exam date 7/22/10; Individual #154, DISCUS date of exam 12/16/10, prescriber review date 12/17/10, last exam date 11/3/10; Individual #146, DISCUS date of exam 12/16/10, prescriber review date 12/17/10, last exam date 9/17/10; Individual #30, DISCUS date of exam 12/15/10, prescriber review date 12/15/10, last exam date 9/2/10; Individual #218, DISCUS date of exam 12/2/10, prescriber review date 12/7/10, last exam date 9/24/10; Individual #53, DISCUS date of exam 12/6/10, prescriber review date 12/7/10, last exam date 9/24/10; Individual #359, DISCUS date of exam 12/16/10, prescriber review date 12/17/10, last exam date

		9/21/10; Individual #378, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/23/10; Individual #131, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/23/10; Individual #19, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/23/10; Individual #175, DISUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/23/10; Individual #333, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/23/10; Individual #147, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/28/10; Individual #304, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/28/10; Individual #355, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/28/10; Individual #376, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/28/10; Individual #198, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/28/10; Individual #363, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/28/10; Individual #136, DISCUS date of exam 12/20/10, prescriber review date 12/21/10, last exam date 9/28/10; Individual #38, DISCUS date of exam 12/29/10, prescriber review date 1/4/11, last exam date 9/27/10; Individual #51, DISCUS date of exam 12/29/10, prescriber review date 1/4/11, last exam date 9/27/10; Individual #42, DISCUS date of exam 12/23/10, prescriber review date 1/4/11, last exam date 9/27/10; Individual #296, DISCUS date of exam 12/29/10 prescriber review date 1/4/11, last exam date 9/27/10; Individual #118, DISCUS date of exam 12/17/10, prescriber review date 1/4/11 last exam date 9/27/10, Individual #117, DISCUS date of exam 12/23/10, prescriber review date 1/4/11, last exam date 9/22/10); Individual #76, DISCUS date of exam 12/29/10, prescriber review date 1/4/11, last exam date 9/22/10; Individual #343, DISCUS date of exam 12/23/10, prescriber review date 1/4/11, last exam date 9/27/10; Individual #371, DISCUS date of exam 12/29/10, prescriber review date 1/4/11, last exam date 9/27/10; Individual #308, DISCUS date of exam 12/29/10, prescriber review date 1/4/11, last exam date 9/27/10; and Individual #225, DISCUS date of exam 12/23/10, prescriber review date 1/4/11, last exam date 9/22/10. o MOSES screenings for the following: Individual #38, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #145, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #30, MOSES exam date 12/15/10, prescriber review date 12/15/10; Individual #147, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #285, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #343, MOSES exam date 12/23/10, prescriber review date 1/4/10; Individual #76, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #131, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #296, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #218, MOSES exam date 12/2/10, prescriber review date 12/7/10; Individual #154, MOSES exam date 12/16/10, prescriber review date 12/17/10; Individual #19, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #9, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #304, MOSES exam date 12/20/10, prescriber review

	date 12/21/10; Individual #355, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #62, MOSES exam date 12/2/10, prescriber review date 12/7/10; Individual #305, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #51, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #117, MOSES exam date 12/23/10, prescriber review date 1/4/11; Individual #175, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #118, MOSES exam date 12/17/10, prescriber review date 1/4/11; Individual #371, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #18, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #225, MOSES exam date 12/23/10, prescriber review date 1/4/11; Individual #376, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #198, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #53, MOSES exam date 12/6/10, prescriber review date 12/7/10; Individual #146, MOSES exam date 12/16/10, prescriber review date 12/17/10; Individual #34, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #333, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #363, MOSES exam date 12/20/10, prescriber review date 12/21/10; Individual #202, MOSES exam date 12/29/10, prescriber review date 1/4/11; Individual #236, MOSES exam date 12/16/10, prescriber review date 12/17/10; Individual #378, MOSES exam date 12/20/10, prescriber review date12/21/10; Individual #359, MOSES exam date 12/16/10, prescriber review date 12/17/10; Individual #308, MOSES exam date not entered, prescriber review date 6/15/10, and exam date 12/29/10, prescriber review date 1/4/11; Individual #42, MOSES exam date 12/23/10, prescriber review date 1/4/11; Individual #136, MOSES exam date 12/20/10, prescriber review date 12/21/10; and Individual #2, MOSES exam date 10/25/10, prescriber review date10/26/10. ▪ **Interviews with**: o Sandi Suri, Pharmacist; and o Minh Nguyen, Clinical Pharmacist.
	Facility Self-Assessment: The Facility's POI indicated it was in compliance with Section N.1, N.2, and N.5 of the Settlement Agreement. In addition to a narrative summary of actions that had been taken to attain compliance, the commentary regarding Sections N.1 and N.2 referenced that record reviews had been completed to determine compliance. Section N.1's summary did not indicate how many records, but Section N.2 indicated nine records had been reviewed. As is detailed below, the Facility's findings were not consistent with those of the Monitoring Team. One of the reasons for the discrepancies between the findings of the internal reviews and the review of the random samples discussed below might be related to a focus, of the internal reviews, on whether a specific requirement was present or absent; whereas the Monitoring Team's review also assessed the quality of those factors.
	Summary of Monitor's Assessment: Based on in-depth review of the eight subsections in depth, there were ongoing concerns in most areas. The new order review was proceeding well, but the quality of the

	documentation when communicating with the prescribing PCP needed improvement. Additionally, during Infirmary rounds, a psychotropic medication normally prescribed at bedtime was ordered as a morning dose according to the Medication Administration Record (MAR). This should have been discovered with the system in place for screening new orders. The information for the review and recommendations listed on the QDRRs was often not located on the QDRR form being filed in the individuals' records. Much valuable data was written only on informal worksheets, which were not part of the record. This is readily correctable. The system of pharmacy input into use of "stat," or immediately administered, medication was not working, because the pharmacy had not received notifications of the use of such medications. A new system was being developed. Reviews of benzodiazepine use and anticholinergic drug load were not included in the QDRRs as required by the Settlement Agreement. The clinical pharmacist completed QDRRs on all individuals residing at CCSSLC each quarter. With regard to review of the recommendations the Pharmacists made, the PCPs were documenting on the QDRR whether there was agreement or not, which was then filed in the individuals' records. This area was found to be in compliance with the Settlement Agreement. The Pharmacy Department did not identify a number of irregularities in the DISCUS and MOSES evaluations. The ADR system was in place. However, there was no evidence of training of PCPs, nurses, or direct support staff on how to recognize or report an ADR. The first DUE was nearing completion, indicating progress in this area. The pharmacy was not yet monitoring all medication errors and variances across the Facility. It was just monitoring those that occurred in the pharmacy.

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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	The pharmacy checked every new order in both the WORx and AVATAR systems. The combination of these two software programs encompassed all the areas needed to review new orders, including review of the individual's medication regimen for significant drug interactions, side effects, and allergies; the need for laboratory testing to monitor for risks associated with the new medication ordered; and dosage adjustment, if not consistent with the standard therapeutic range.	Noncompliance

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	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.	The number of patient interventions (i.e., contacts made by the pharmacist to the practitioner concerning a medication order) varied across the months. In July, there were 12 patient interventions, with five records providing no information about the intervention. In August there were 21 patient interventions entered. Of these, one did not list the name of the medication, making it difficult to interpret (unless one had the information to track the visit identification). There was no information regarding the specific reasons for the intervention (assessment or recommendation) for 17 of these 21 interventions. In September, there were 27 patient interventions. There was one in which a medication name was not listed. For the other 26 interventions, there were no entries under the subheading "Recommendations." Documentation changed beginning in October 2010. During this month, there were a total of 21 patient interventions. Five did not mention the name of the medication being discussed, and three had no information regarding the recommendations made. In November 2010, 18 had no medication named, and there was only one with no information entered. In that month there were 59 patient interventions listed. The large number of patient interventions was due to the additional updated diagnoses entered into the database. In December, there were five forms that did not list a name of the medication, and there were four with no information entered regarding recommendations. There were a total of 27 patient interventions during this month. Some of the communications between the Pharmacy Department and the Medical Department were excellent, discussing drug interactions, dosages, etc. Overall, the documentation regarding the critical thinking on the part of the pharmacy had improved in several ways. There were more patient intervention entries compared to the last visit, and there was considerably more information available. However, attention should be paid to naming the medication, and ensuring that the reason for the patient intervention is documented rather than left blank. The low July numbers suggested patient interventions were not routinely documented. Overall, the compliance rate for appropriate documentation was 58% based on information provided. For August, the compliance rate for appropriate documentation of the patient intervention was 14%; in September, it was 0%; in October, it was 62%; in November, it was 68%; and in December, it was 67%. The Plan of Improvement also indicated that the intervention was not only noted in the WORx system, but also was documented on the order itself. Examples of providing information on the order sheet were provided, and physicians made changes based on this information. The following were examples of individuals with the medication name that was changed/adjusted: Individual #350/iron supplement, Individual #34/lipid lowering agent, Individual #38/Vitamin D, Individual #46/tetracycline, and Individual	

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		#104/Vitamin D. However, the order sheet might not be the best place for the Pharmacist to comment. It made the order sheet difficult to interpret when the Pharmacy Department added side notes. The order sheet should be reserved for orders and nursing documentation related to transcribing the orders. The Pharmacy Department comments are important, but an alternative place for this documentation should be identified. Further, the quality of the interventions might need review. For example, Individual #269 received Seroquel in the morning instead of the evening. The Pharmacy should review of the steps that allowed this to occur. This incident indicated a need for quality control of the pharmacist's review of the orders. As part of this process, a policy was revised, entitled Pharmacy Services and Safe Medication Practices N.9: Notification of a prescriber regarding potential unexpected or undesired outcomes with addition of a new medication in combination with existing medication regimen including supporting documentation, revised 12/30/10. It streamlined the process and options, and made them more understandable. According to the Plan of Improvement, allergy lists for all individuals were reviewed to ensure there was no misinformation or confusing information. A protocol was developed which outlined the steps the pharmacist took in reviewing allergies when processing an order. It was entitled "Protocol for checking the allergies when entering the orders." Four steps were outlined. A date of implementation should be included on the form for future reference. Information in the database concerning allergies of the individuals was dependent on completeness and accuracy of information gathered from a variety of sources. In the past, the pharmacy did not have a system to ensure that any adverse drug reaction or allergy while at the hospital was communicated to the pharmacy for timely placement in the computerized database. A system was developed for this purpose, including completion of a form: Allergy/ADR reporting form for individuals discharged from hospital. The Pharmacy Director reported that the hospital liaison nurse was responsible for communicating any allergy or ADR, while the individual was hospitalized, by completing the form developed to communicate this information. The form was reviewed, and it was noted that there was no implementation date, or other method of identification. This information should be added in order to identify which form is the most recent. According to the Plan of Action, the pharmacy received a copy of the discharge medication summary of the patient, which was then checked by the pharmacist for any new allergies. If new allergies were identified, this information was then entered into the WORx system. Additionally, the pharmacy retained a copy of the discharge	

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		summary sheet. Although progress had been made in this area, there remained issues regarding documentation of interventions implemented to address Pharmacists' concerns. In addition, although only one such issue was identified on-site, regarding the timing in which a medication was being administered, it called into question the quality of the Pharmacy Department's review. Largely due to the lack of adequate information recorded regarding interventions, the Facility remained out of compliance with this provision.	
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.	Forty recent Quarterly Drug Regimen Reviews were assessed to determine if laboratory results were reviewed, and if abnormal results or therapeutic levels were abnormal (high or low). The full listing of the QDRRs reviewed is contained in the Documents Reviewed Section above. Three forms were submitted for this process. The Quarterly Drug Regimen Review sheet was a page with the pharmacist's findings in the areas of assessment of the drug regimen required by the Settlement Agreement, along with a space for recommendations and comments. This first document was placed in the record as the approved QDRR. A separate form was a drug regimen review profile generated from the computer, which included handwritten, and, at times, crossed out notes with laboratory results, including indications if they were considered high or low, as well as MOSES and DISCUS scores, if applicable. The entries were written on the page in an informal manner and were not necessarily organized. For example, the handwritten information was randomly jotted on the page without any semblance of order or structure. This second document might or might not have been placed in the record, but did not appear to be part of the QDRR. It appeared that based on this analysis, the Pharmacist made recommendations on the QDRR. However, if the reader went to a QDRR, there was no information to indicate how a pharmacist came to these conclusions, based on a lack of background information on the page. The third document was a Quarterly Medication Review Worksheet. This was a document the Pharmacy Department used internally. At the time of the review, the QDRR appeared to be just the formal first page with the heading identifying it as the QDRR. Based on this, the QDRRs were not compliant with the requirements of the Settlement Agreement, except for three QDRRs for which laboratory results were not needed/indicated. Additionally, one document had no lab results, but indicated lab results were pending. The remaining 36 out of 40 did not have appropriate lab results on the QDRR sheet. Compliance was four out of 40 (10%). It is recommended that the QDRR include the important lab data. A formal table could be created, so data is not haphazardly written on a page.	Noncompliance

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		The lab results maintained by the Pharmacy were reviewed appropriately in 35 out the 36 reviews for which they were applicable (97%), but again this information was not included in the QDRR. There was one QDRR, for Individual #130, on which a Dilantin level and a Thyroid Stimulating Hormone (TSH) would have been expected to be available, but were not included. In the past, at times, the QDRR inadvertently bypassed the PCP and was referred to the psychiatrist, if the review focused on psychotropic medication. At the time of the most recent review, when the psychiatrist commented on the QDRR, the original QDRR was then forwarded to the PCP for review and signature before being filed. The State ICF/MR survey team completed an ICF-MR survey on 9/3/10. Several individuals were found not to have QDRRs for various quarters of the year reviewed. It was noted that the Facility did not have a tracking system to ensure all individuals had QDRRs completed in a timely manner. To assist in resolving this problem, it was decided that the Medical Program Specialist would be responsible for tracking QDRRs and would also maintain a file of copies as they are completed. Although progress had been made, the laboratory results, and the Pharmacists' analysis of these, were not formally part of the QDRR record. This is necessary for compliance with the Settlement Agreement to be achieved.	
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	This provision of the Settlement Agreement encompasses a number of requirements. Each of these is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints. This discussion will also include benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Medications and Chemical Restraints</u> The Facility submitted a document entitled "Restraints-monthly trending report," including the months of July through December 2010. In this document, one of the sections focused on chemical restraints. The following numbers of chemical restraints were listed: July – 5, August – 6, September – 5, October – 5, and November – 2. This report additionally had easy-to-read charts and graphs, which broke down chemical restraint use by residence of individual, usage by residential unit, location of usage of restraint (living room, etc.), usage by day of the week, usage by hour of the day, usage by shift, usage by behavioral causes (SIB, aggression, etc.), and usage by restrictive level. This information allowed the PSTs to begin to analyze this usage information for trends, identify potential options for reducing usage, and monitor progress.	Noncompliance

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	use of new generation antipsychotic medications.	In a separate document entitled "Individuals Restrained with Chemical Restraint during time period between 7/1/10 – 12/31/10," the following numbers of chemical restraints were listed: July – 5, August – 8, September – 5, October – 6, November – 2, and December – 0. There was a discrepancy in the months of August and October with regard to the number of chemical restraints. This indicated the need to reconcile data between departments to ensure consistency and accuracy of information. A number of documents were submitted concerning monitoring the use of chemical restraints. In each incident of chemical restraint packet, various forms were completed, including the Restraint checklist, Face-to-Face Assessment, and Debriefing and Reviews for Crisis Intervention Restraint. In this last document, Section 9, there was the space for a comment from the pharmacist. The guidance note for the "Chemical Restraint Clinical Review" stated: "Note if documentation indicates whether the medication was used in a clinically justified manner, the potential medication related risks that should be considered, and actions/recommendations, if any." Of the 14 chemical restraint packets submitted, two (14%) had comments by pharmacy staff, followed by name of the pharmacist and date. Specifically: ▪ Individual #95 received Haldol and Ativan on 9/22/10. The comment from the pharmacy staff was that the medication was clinically justified. There was no information as to how the pharmacist came to that conclusion, nor was there a discussion of the potential drug-drug interactions, which was mentioned as a concern by the psychiatrist. ▪ Individual #7 received Zyprexa on 9/28/10. There was no comment regarding whether or not the medication was justified, or of the risks that should have been considered. However, there was a recommendation noted, although no information reflecting the critical thinking leading to the recommendation was included. Recommendations should have a brief discussion of risk/benefit and comparison to other options, especially because the psychiatrist indicated the medication was used appropriately. The pharmacist recommended redirection techniques rather than a chemical restraint. These two cases did not provide good examples of the guidance that the Pharmacy Department could offer regarding future use of chemical restraints with the individual(s). Neither mentioned the history of chemical restraint use with the individual(s), which would be of importance in determining the need to review maintenance medication if this was a frequent occurrence. Alternative medication regimens were not suggested. Additionally, for Individual #246, who received Ativan as a chemical restraint on 10/7/10, there was a brief entry that the medication was clinically justified, but there	

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		was no further synthesis of information, or guidance and recommendation, nor was it signed or dated. It was not clear who typed in the entry stating that the restraint was clinically justified. There were a number of other events of chemical restraint use in which the pharmacy did not complete the Face-to–Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint form. These included the following forms which were incomplete: Individual #297, date of restraint 9/20/10; Individual #133, date of restraint 11/29/10; Individual #268, date of restraint 10/9/10; Individual #75, date of restraint 8/6/10; Individual #75, date of restraint 8/11/10; Individual #118, date of restraint 9/2/10; Individual #118, date of restraint 9/7/10; Individual #118, date of restraint 9/11/10; Individual #118, date of restraint 9/20/10; Individual #7, date of restraint 8/8/10; and Individual #357, date of restraint 8/11/10. These eleven chemical restraint forms had no input from pharmacy, suggesting they had not been routed to the Pharmacy Department. In total, none of the 14 chemical restraint forms adequately reflected the expertise of the Pharmacy Department. In particular, one individual, Individual #118, had several chemical restraints, suggesting the need for consultation and assistance, but the Pharmacy Department was not part of this consultation process. Compliance was zero out of 14(0%). It also should be noted that these Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint reports totaled four for 8/10, seven for 9/10, and two for 10/10. These numbers did not agree with other of the database printouts already mentioned. The Monthly trending reports indicated six chemical restraints in 8/10, five in 9/10, and five in 10/10. The Individual Restrained with Chemical Restraint During time period between 7/1/10 and 1/3/11 included eight in 8/10, five in 9/10, and six in 10/10. Another database, TX-CC-1101-II.6.a, listed eight chemical restraints in 8/10, seven chemical restraints in 9/10, and five chemical restraints in 10/10. There remained considerable need for coordination, communication, and accurate data collection to determine the extent of chemical restraint use at CCSSLC. At the time of the Monitoring Team's visit, the Pharmacy Director reported that the Pharmacy Department was aware that chemical restraint use was not being reported to the pharmacy and forms were not arriving for timely completion. There recently had been a revision of the process. There was one person assigned to chemical restraint documentation, and this staff member was responsible for navigating the paperwork to the Pharmacy and other departments in a timely manner. The Pharmacy Director was aware of specific chemical restraint use that had not been reported (as of the Monitoring	

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		Team visit) to the Pharmacy Department. However, the passive role of waiting for a form to arrive days to weeks later, if at all, did not fulfill the role of pharmacy in ensuring safe medication practices at CCSSLC. The Pharmacy Department should be assisting the system in any way possible to ensure chemical restraint reviews occur in a timely manner. Benzodiazepines, Anticholinergics, Polypharmacy, and Second Generation Antipsychotics Forty recent QDRRs were reviewed to determine the Pharmacy Department's role monitoring the justification and risks of benzodiazepines, anticholinergics, and polypharmacy, and in monitoring the metabolic and endocrine risks associated with the new atypical antipsychotics. The QDRRs reviewed are listed above in the Documents Reviewed section. For the benzodiazepines, there was no specific comment about the use of benzodiazepines, and so there was no evidence of direct monitoring of this class of medication. There was no differentiation of benzodiazepine use for seizure disorders, or psychiatric diagnoses, or other conditions (spasticity), effectiveness, etc. Of the 40 QDRRs, only six individuals were prescribed benzodiazepines. The compliance rate for monitoring this specific class of medication was zero out of six (0%). Additionally, the 12/14/10 P&T Committee meeting indicated that there had been a reduction in benzodiazepine use from 2009, although there was no data or statistics to support this statement. It is recommended that precise information be included in the P&T Committee meeting minutes. For example, the percent reduction in total doses prescribed from the previous year, or percent reduction in individuals administered this class of medication should be included. Such information will demonstrate the successful impact of a QDRR program. The Plan of Improvement provided information that was valuable. It documented that 62 individuals were on benzodiazepines in 2009, and in 2010 that number had dropped to 35 (a 42% reduction). This information should be included in the P&T minutes. There was also no review of anticholinergic activity in the drug regimen reviews. Anticholinergic drug load would be valuable in guiding physicians and teams to choose medication that was less anticholinergic, or to reduce medications with this significant side effect. However, it was not addressed. It is recommended that these two categories, benzodiazepines and anticholinergics, be added to the yes/no required assessment section at the top of the QDRR, to ensure appropriate review of each individual's drug regimen. The Pharmacy Department reviewed polypharmacy as part of the QDRR. In 26 records reviewed, there was no polypharmacy. There was polypharmacy identified in 14 QDRRs.	

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		This was not only inclusive of psychotropic medication, but all other classes of medications. This was appropriately identified in all 14 cases. The standardized questions, following the assessment of polypharmacy, appeared to address appropriate dosage and delivery, drug interaction risks, monitoring and effectiveness, side effects, toxicity, or adverse effects, followed by the general statement that pharmacotherapy was appropriate. Compliance was 14 out of 14 (100%). For those on atypical antipsychotic medication, monitoring of endocrine and metabolic risks was also documented through the QDRR process. Of the 40 QDRRs reviewed, 12 individuals were taking antipsychotics. One individual on antipsychotics, Individual #326, was on Iloperidone, but there were no lab data to suggest monitoring for metabolic concerns. Compliance was 11 out of 12 (92%). Additionally, polypharmacy for psychotropic medication was tracked through the CCSSLC Monthly psychiatric services review (PSR). A number of individuals with psychotropic polypharmacy were reviewed at these meetings, with minutes generated. The purpose of the meeting was to ensure clinical justification for the use of the psychotropic use, and to monitor for endocrine and metabolic risks for those on the new generation antipsychotic medications. The meeting minutes were in narrative form, and were full of helpful information. For a quick review of the contents, some of the highlights of the clinical information could be placed in a table, perhaps in an appendix, which might include information by individual discussed, such as: psychotropic medications, most recent blood levels therapeutic (yes/no), change in dosage recommended by psychiatrist for each psychotropic medication (yes/no), effectiveness of each drug (yes/no), observed side effects, etc. In a one-page format, one could see the most important information discussed. Further discussion regarding this committee's work is included with regard to Section J.11 of the Settlement Agreement.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	These same 40 QDRRs were reviewed to determine whether the primary care practitioners were reviewing the pharmacist's recommendations, and whether they were implementing these recommendations or documenting the reason for not implementing the recommendations. For the 40 QDRRs reviewed, 15 had no recommendations. Of the remaining 25 QDRRs, 14 had evidence that the primary care providers followed the recommendations. For 12 QDRRs, the primary care provider did not agree and wrote a clinical rationale on the QDRR. For 3 of these QDRRs, there was more than one recommendation, and one recommendation was accepted and one was not, but had a reason documented. There were two QDRRs that had no information as to follow up. In one case, involving Individual #369, a diagnosis clarification for onychomycosis was requested, but the PCP responded it was not ordered through the PCP. It was not clear if this was then referred	Substantial Compliance

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		to the podiatrist or specialist. There was no information submitted to determine if it was addressed. With the second case, a DISCUS was overdue, and was referred to the PCP, but there was no information documenting closure of the recommendation. For the 25 QDRRs with pharmacy recommendations, compliance, based on evidence that the recommendation was reviewed and carried out, or documentation of the rationale for not agreeing with the recommendation, was present in 23 out of 25 QDRRs (92%). Additionally, according to the Plan of Action, the medical morning meeting was a forum used to discuss any concerns about pharmacy recommendations. Pharmacy and medical staff were both represented at the meeting. It also was noted that the physicians were generally not completing the lower right hand corner check boxes indicating agreement or disagreement with the pharmacy recommendations. If this section is to be used, PCPs and Psychiatrists should be in-serviced and monitored to ensure its appropriate completion. If the PCPs are documenting elsewhere on the form, then this area should be removed, providing more space for lab values and other required assessment questions. Additionally, the Pharmacy Department completed a draft/revision of the policy, Pharmacy Services and Safe Medication Practices N.1: Quarterly Drug Regimen Review. The draft/revision date was 9/2/10. An additional form was used in the QDRR process, a Quarterly Medication Review Worksheet. The revised policy clarified the steps in routing the form. It did not address the need for the physician to document a reason if there was disagreement with the Pharmacy Department's recommendation. Although as noted above, the practice of physicians documenting a reason for disagreement with a recommendation from the Pharmacy Department appeared to be well established, CCSSLC should add this requirement to its policy.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	A total of 31 DISCUS evaluations were reviewed. The specific evaluations are listed above in the Documents Reviewed section. Based on this sample, the monitoring for Individual #30 was overdue by 13 calendar days. Others were overdue lesser amounts of time (i.e., Individual #2 - three days, Individual #38 – three days, Individual #51 – two days, Individual #296 – two days, Individual #117– one day, Individual #76 - seven days, Individual #371 – two days, Individual #308 – two days, and Individual #225 – one day). This was a compliance rate of 21 out of 31 (68%). Given the advance knowledge of approaching due dates, and the ability to place this information into a database and track it precisely, there is little reason not to have the rater exam date completed by the due date. However, the prescriber review date also needs to be taken into consideration, and these should be completed within a few days after the rater exam date. The prescriber review date was usually done promptly, but was, in some instances,	Noncompliance

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		delayed for several days. Examples included the DISCUS review on the following individuals: Individual #38 - 6 days, Individual #51 – 6 days, Individual #42 – 12 days, Individual #296 – 6 days, Individual #118 – 18 days, Individual #117 – 12 days, Individual #76 – 6 days, Individual #343 – 12 days, Individual #371 - 6 days, Individual #308 – 6 days, Individual #225 - 12 days, Individual #218 – 5 days, and Individual #176 - 4 days. When the monitoring date was beyond 90 days and the prescriber review date exceeded two to three days (up to 18 days in one of the above examples), then the DISCUS was finalized several days to two or more weeks beyond the 90-day time period. Although there are various "grace" periods allowed for such measurement tools, the impact of late monitoring on the individual can be significant, especially if there are medication side effects developing. The goal for completion of each DISCUS, including both exam and prescriber review, should be within the 90-day window of the prior DISCUS evaluation and review. Using this threshold, then the compliance rate was 18 out of 31 (58%). Additionally, the prescriber review date should be within seven calendar days of the rater exam date. Using this threshold, then five of the above DISCUS reports went beyond this. This was a compliance rate of 26 out of 31 (84%). If it has not already occurred, it is recommended a policy be developed or clarified defining the acceptable time frame between an exam date and prescriber review date, and that the time frame be of short duration. Forty completed MOSES evaluations were submitted for review. These are listed above in the Documents Reviewed section. Several concerns arose in reviewing these documents. For those that were copied, but not copied using the two-sided function, the second page had no identifying name. There was a single first page copied, but the second page was not next in the order. To avoid issues related to copying, the individual's name should be placed on the second page to ensure proper identification. Additionally, the signature of the prescriber should be typed or printed. It was not clear if the prescriber was a psychiatrist, PCP, or other practitioner. Additionally, in several instances, the date was also unclear and left to interpretation. Moreover, there was no reference to the date of exam or the prior MOSES score. A copy of the prior completed MOSES form for this sample of individuals was requested, but not provided. Therefore, there was no data to determine if the MOSES evaluations provided were timely. Compliance could not be verified for any of the individuals in the sample. The QDRR also should reflect the dates of the most current, and prior MOSES and DISCUS, because this is important information for the PCP. However, only the most current date of exam was listed. The Pharmacy Department should ensure that MOSES and DISCUS are completed in a timely manner.	

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		Similar to the DISCUS, there were examples of several days between the exam date and the prescriber date of review. Examples included: Individual #343 – 12 days, Individual #117 – 12 days, Individual #118 – 18 days, Individual #225 – 12 days, and Individual #42 - 12 days. Based on a maximum acceptable time, between exam date and prescriber review, of seven days, then the compliance rate for the prescriber review was 35 out of 40 (88%). A policy should clarify the amount of time allowed between the exam date and prescriber review.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The Pharmacy Department submitted a policy recently completed entitled Pharmacy Services and Safe Medication Practices N.6: Adverse Drug Reaction Policy, developed 11/12/10. An Adverse Drug Reaction Reporting Form was a part of this policy. This form was to be completed each time an adverse drug reaction occurred. According to the Plan of Improvement, the ADR policy was augmented with a probability scale to assist in analyzing the severity of reactions and need to report to MedWatch. There was one adverse drug reaction reported in the prior six months. This was on 10/26/10, and involved the administration of intravenous (IV) Reclast. The individual was sent to the hospital for evaluation of high fever, tachycardia, and shortness of breath. There were many medications and many doses of medications prescribed at CCSSLC each month as part of ongoing medical care. One would anticipate more than one ADR during this time. Considerable training is needed of all staff caring for the individuals, including PCPs, nursing staff, and direct support professionals, so staff begin to observe for ADRs and know what information to report and to whom to report this information. No training documents were submitted. Additionally, during the week of the Monitoring Team's visit, Individual #214 developed a fever from IV Reclast. This was discussed on daily rounds in the Infirmary. The PCPs and nurses were challenged to consider whether or not this met the criteria of an ADR. There seemed to be a lack of knowledge of the policy and criteria used in determining an ADR, which indicated the need for training (and retraining) across the Facility.	Noncompliance
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	The Pharmacy Department completed a policy entitled Pharmacy Services and Safe Medication Practices N.7: Drug Utilization Evaluation Policy, which was implemented 11/3/10. The pharmacy was unable to provide a drug utilization evaluation calendar for the year, listing which medication would be evaluated each quarter. The P&T Committee had not yet determined this. This was listed as a requirement in the Health Care Guidelines, as well as in the Facility policy of 11/3/10, under "Procedures 2." A drug utilization evaluation was conducted during the period between 10/1/10 and	Noncompliance

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	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.	12/31/10. The drug evaluated was Olanzapine. A copy of the data collection form and the report the Pharmacy Department had drafted was submitted. Of 29 individuals prescribed this medication, a sample size of 10 was selected. There were several findings, according to the report, which remained unofficial until presented to the P&T Committee for review and interpretation, as well as discussion of next steps. Of concern was the small sample size of 10, which might skew or magnify results compared to the results of a larger sample size. Considering the results, it might be important to do a larger study of all individuals on Olanzapine to determine if the smaller sample was accurate. However, this was the first DUE at CCSSLC, and the process had not been completed, including approval and interpretation by the P&T Committee, as well as development and implementation of action steps to reduce the irregularities and undesirable trends the evaluation highlighted. According to the minutes of the 12/14/10 P&T Committee, the DUE on Olanzapine was to be presented at the next P&T meeting. As indicated in the Plan of Improvement, the Facility recognized it remained out of compliance with this provision of the Settlement Agreement. Progress had been made, however, in beginning to conduct DUEs.	
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 Medication Error Committee was merged with the Medication Administration Committee to become the Medication Committee. Minutes from the Medication Error Committee meetings were reviewed, including those for meetings held on 6/24/10, 7/22/10, 8/6/10, 9/16/10, and 10/15/10. The 8/6/10 minutes indicated medication errors were not being reported when they originated from the PCP. However, there was no example given, nor any next step to either clarify this statement or take action to resolve the issue. The statement also was made that the reporting of medication errors had improved. Again, no data were provided or basis for this statement. The 10/15/10 minutes indicated that a frequently stated reason for a medication error was "distraction," and that it was rarely described. This was a good observation, and had the potential to assist in reducing the medication error rate once resolved. Nurse managers were to encourage staff to describe the distractions. There were no further minutes submitted that reflected follow up of this issue. The Medication Committee met on 11/30/10, but did not address this issue further. It would be helpful to determine the percentage of medication errors caused by distractions, what the distraction actually was, and options for preventing the distractions. On 11/30/10, the Medication Committee reported significant decreases in omissions, and also improvement in medication pass observations. However, there were no data	Noncompliance

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		presented to confirm these statements, and/or provide information about the degree of improvement. In general, the P&T Committee minutes played a valuable role in communicating pharmacy issues across the Facility. In the 12/14/10 P&T Committee meeting minutes, there was the statement: "There was a significant reduction in benzodiazepine usage." However, it is recommended that the data that drives the statements and conclusions be documented. It also would be important to have a section tracking the medication error or medication variance rate per month as part of the P&T minutes. The Medication Error Committee and Medication Committee did not report this information. Various tables were submitted providing medication errors by month and by unit. The tables listed information from September 2009 through August 2010, as well as September 2010 through November 2010. A total of 14 medication errors were listed for the last quarter of September through November 2010. A separate table listed the errors by residence, category and type. Most errors were errors of dose or omission. Another table listed procedural medication errors, which was interpreted as errors of omission. These had substantially greater numbers, 262 for September, 197 for October, and 129 for November. In reviewing the SSLC Medication Error Reports for September through November 2010, only nine reports were submitted for this time period (versus 14 in the earlier database). The databases should be reviewed to determine which is the most accurate. The reason for tracking information in several separate databases was not clear, and the goal should be to have one database for medication error tracking. As part of the ongoing monitoring of medication administration, observations of medication passes were being completed. The tool for completing these observations was called the Medication Passes Assessment Tool. Its implementation is discussed in further detail with regard to Section M of the Settlement Agreement. The Pharmacy Department should take a more active role in creating a system for reviewing medication errors and variances, and reducing their incidence. Their role is not simply to ensure minimal medication errors are made by the pharmacy. The Nursing Department should share additional information related to medication variances with the Pharmacy Department. The Pharmacy Department should be responsible for database management and trend analysis. The corrective action process should be a collaborative one. However, for some trends identified, the Pharmacy Department might be able to use their expertise in creating systems with less potential for errors.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The order sheet should be reserved for orders and nursing documentation related to transcribing the orders. An alternative place for the Pharmacy Department's documentation should be identified.
2. The Pharmacy Department should develop an internal QA system for the new orders that are received, especially with psychotropic medication, to ensure the quality of the review conducted.
3. Laboratory results contributing to the Pharmacy Department's recommendations should be included on the formal QDRR form.
4. Efforts should be made to reconcile the data collection for chemical restraints across different databases. There should be collaboration between the Pharmacy and other departments to develop one reliable source of information.
5. The Pharmacy Department should provide detailed information on the chemical restraint forms, including recommendations and the reason(s) for recommendations, drug interactions, history of prior chemical restraint use, and discussion of other medication options.
6. The QDRR review should include specific information about benzodiazepine use and anticholinergic effects of medication.
7. In the Pharmacy and Therapeutics Committee minutes, data (either directly in the minutes or as an appendix) should be provided to justify any summary findings or general statements.
8. MOSES and DISCUS completion should be tracked in a database to ensure all individuals are monitored in a timely manner, and PCP reviews are completed timely.
9. If not already in policy, it is recommended that for DISCUS and MOSES completion, both the exam and prescriber review be completed within 90 days of the prior review, and that the prescriber review be within seven days of the exam.
10. There should be Facility-wide training on Adverse Drug Reactions, especially on the identification of an adverse drug reaction and how to report it.
11. The Facility should complete a 12-month Drug Utilization Evaluation calendar.
12. Medication Committee minutes should include closure to issues raised in prior meetings. The minutes should include data to support general statements.
13. The Pharmacy & Therapeutics Committee minutes should include a section that specifically tracks medication errors and variances, and includes analysis and discussion.
14. The Pharmacy Department should take a more active role in creating a system for reviewing medication errors and variances, and reducing their incidence. Their role should not simply be to ensure minimal medication errors are made by the pharmacy.
15. The Nursing Department should share additional information related to medication variances with the Pharmacy Department.
16. The Pharmacy Department should be responsible for database management and trend analysis related to medication variances.
17. The Pharmacy Department should document corrective systems plans to prevent future pharmacy medication errors in P&T Committee meeting minutes, if not recorded elsewhere.
18. There should be collaborative efforts to identify trends and options for systems improvement so that the same errors do not recur. This likely will require the involvement of many departments, including but not limited to, the Pharmacy, Nursing, Medical, QA, and Residential Departments. These efforts should be documented clearly in the Medication Committee meeting minutes.

The following are offered as additional suggestions to the State and Facility:

1. Protocols, polices, and forms should have dates of implementation for identification and future reference.
2. The QDRR checkbox for physician agreement/non-agreement should be removed if an alternative option for documenting this has proven effective. If the box is to be used, the physicians should be provided in-service training on the purpose of this checkbox and its completion.
3. CCSSLC should add a requirement to its policy to memorialize the requirement that physicians document a reason for disagreement with a recommendation from the Pharmacy Department.
4. The second page of the MOSES tool should have the individual's name and date of exam listed for identification purposes.
5. For a quick review of the minutes of the monthly Psychiatric Services Review minutes, some of the highlights of the clinical information could

be placed in a table, perhaps in an appendix, which might include information by individual discussed, such as: psychotropic medications, most recent blood levels therapeutic (yes/no), change in dosage recommended by psychiatrist for each psychotropic medication (yes/no), effectiveness of each drug (yes/no), observed side effects, etc. In a one-page format, one could see the most important information discussed.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section O; o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) Assessments, Physical Nutritional Management Team (PNMT) Comprehensive Assessment, Nursing Care Plan, OT/PT/SLP consultations for the last year, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan (PNMP) with pictures, Nutritional Management Team (NMT) Individual Record with recommendations, PNMP person-specific monitoring for the past year, PNMP Clinic Notes, competency-based training for staff for PNMPs, and dining plan for the following 11 individuals: Individual #270, Individual #316, Individual #130, Individual #375, Individual #42, Individual #141, Individual #378, Individual #131, Individual #31, Individual #158, and Individual #113; o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology Assessments, PNMT Comprehensive Assessment, Nursing Care Plan, OT/PT/SLP consultations for the last year, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan with pictures, Nutritional Management Team Individual Record with recommendations, PNMP person-specific monitoring for the past year, PNMP Clinic Notes, competency-based training for staff for PNMPs, and dining plan for the following 15 individuals: Individual #246, Individual #284, Individual #160, Individual #43, Individual #348, Individual #173, Individual #320, Individual #58, Individual #297, Individual #2, Individual #139, Individual #153, Individual #207, Individual #247, and Individual #311; o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology Assessments, OT/PT/SLP consultations for the last year, Nutrition Assessment, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan with pictures, and pleasure/therapeutic feeding program/plan for the following eight individuals: Individual #240, Individual #64, Individual #210, Individual #21, Individual #209, Individual #315, Individual #245, and Individual #77; o List of individuals with corresponding residences and date of most recent PSP, undated; o List of individuals along with date of admission and legal status, undated; o Agenda for new staff orientation, revised 11/10; o Schedule for in-service staff training, 12/10 through 1/11; o List of individuals who have died and those who have transitioned into the community, 7/10 through 11/10; o List of all Incidents and/or Injuries from 11/09 through 11/10, dated 11/18/10; o List of individuals who have sustained a bone fracture between 11/09 and 11/10, dated 12/15/10;

		- List of individuals who have incurred an injury requiring a suture or Dermabond between 11/09 and 11/10, dated 12/15/10; - Quality assurance/enhancement reports generated between 6/1/10 and 8/31/10, dated 9/20/10; - Minutes from all QA/QI Committee, PIC, PIT, and PT meetings, 9/10 through 11/10; - List of individuals with corresponding most recent PSP meeting date, 12/09 through 11/10; - List of individuals identified to be "at risk" for various categories, dated 11/24/10; - List of Core and Alternate PNMT Members, undated; - PNM Policies and Procedures related to Physical Nutritional Management and Nutritional Management (NM) Team, dated 12/17/09; - PNM Policies and Procedures related to OT/PT Services, dated 10/7/09; - PNMT Policies and Procedures related to team members and their roles and responsibilities, dated 11/5/10; - CV's for PNMT members, various dates; - List of PNMT Webinars and Continuing Education (CE) Activities from 7/10 through 11/10; - Minutes and Documentation of Attendance for Speech/Hearing Webinars, PNMP/Clinic Webinars, NMT/PNMP/Equipment Webinars from 7/10 through 10/10; - PNMT Minutes, 7/10 through 10/10; - List of Individuals reviewed at Health Status Team Meetings, 7/7/10 through 11/30/10; - PNMT Reports on multiple Individuals, 8/10 through 11/10; - PNM Policies and Procedures related to At-Risk Individuals, dated 10/10; - PNM Tools utilized to screen and identify health risk levels, dated 10/10; - List of individuals who have PNM needs, dated 11/22/10; - List of individuals who do not have PMN needs, dated 11/24/10; - Tools used to assess PNM status and needs (blank), undated; - PNMT Evaluations on multiple individuals, 7/10 through 12/10; - PSPs for multiple individuals, 11/09 through 8/10; - PNMPs for multiple individuals, 12/09 through 11/10; - Tools used to monitor implementation of PNM procedures and plans, 2010; - PNM Monitoring Tools completed for multiple Individuals, 8/10 through 11/10; - Tools utilized for validation of PNM Monitoring, 7/10 through 9/10; - POI Monitoring Tools for Sections O, P, and R, 5/10 through 10/10; - Guidelines for NMT Review Updates, undated; - Dining Plan Template, undated; - PNMPs and Dining Plans for selected individuals (10%) in each Risk Category, dated 11/19/10; - Competency-based Training Sheets related to Dining Plans, 9/10 through 11/10; - Draft of PNMT database, undated; - List of Individuals on Modified Diets/Thickened Liquids, dated 11/17/10 and 11/19/10; - List of Individuals whose Diets have been Downgraded during past 12 months, undated;

	○ List of Individuals with Body Mass Index (BMI) equal to or greater than 30 (≥), undated; ○ List of Individuals with BMI equal to or less than (≤) 20, undated; ○ List of Individuals who have Unplanned Weight Loss of 10% or greater over six months, undated; ○ List of Individuals who have had: a Choking Incident, a Pneumonia Incident, a Skin Breakdown, or a Slip/Fall between 11/1/09 and 11/16/10, dated 11/19/10; ○ List of Individuals who have had a Fecal Impaction during past 12 months, undated; ○ List of Individuals who are considered to be At Risk of: Choking, Falls, Skin Breakdown, Fecal Impaction, Osteoporosis/Osteopenia, Aspiration, and Pneumonia, along with their corresponding risk severity, dated 11/19/10; ○ List of Individuals with Poor Oral Hygiene, dated 11/23/10; ○ List of Individuals who receive Nutrition through Non-Oral methods, dated 11/17/10; ○ List of Individuals who have received Videofluoroscopy, Modified Barium Study (MBS), or other Diagnostic Swallowing Evaluation including findings and follow-up plans, 2010; ○ Meal Schedule by residence, undated; ○ Schedule of all PNM-related meetings during week of on-site review, 1/3/11 through 1/7/11; ○ Training Curricula for PNM Staff including all training materials and any recent revisions, various dates between 2004 and 2010; and ○ Tools and Checklists used to provide Competency-Based training for PNM foundational skills, various dates between 2004 and 2010. ▪ **Interviews with**: ○ Dr. Angela Roberts, AU.D., CCC-A, F-AAA, Habilitation Therapies Director and Audiologist; ○ Maria Dominguez, RN and Core PNMT Member; ○ Nancy Droke, OT and Core PNMT Member; ○ Cheri Gonzales, RD and Core PNMT Member; ○ Janie Mendoza, PT, CWS, FACCWS, and Chairperson of Core PNMT; ○ Noela Morales, MS, CCC-SLP, and Core PNMT Member; ○ Maria Garcia, PT and Alternate PNMT Member; ○ Tami Loudermild-Flores, OT and Alternate PNMT Member; and ○ Linda Merryman-Scifres, BS, SLP and Alternate PNMT Member. ▪ **Observations of**: ○ Core PNMT Meeting, on 1/4/11; ○ Core PNMT and PST Meeting for Individual #247 on 1/5/11; ○ At-Risk Meeting and Aspiration Pneumonia Initiative Overview Meeting on 1/3/11; and ○ Observations in Apartment 515, Apartment 516, Dining Room of Apartment 522-A, Apartment 522-B, Apartment 522-C and Apartment D.
	Facility Self-Assessment: The Plan of Improvement for Section O documented noncompliance for all eight indicators in Section O. The POI provided chronological updates in the comments/status column of what had been accomplished to date. An additional POI form provided the following fields for Sections O.1, O.3 and O.5:

	▪ Compliance Visit/Section and Recommendation; ▪ Outcome; ▪ Action Step; ▪ Evidence; ▪ Responsible person; ▪ Start date; ▪ Target date; and ▪ Completion Status. The Facility's assessment of their status with regard to compliance for Section O was consistent with that of the Monitoring Team. POI Monitoring Forms were submitted for Section 0 from May 2010 to September 2010. Occupational Therapist(s), Physical Therapist(s), Physical Therapy Assistant(s) (PTAs), and Certified Occupational Therapy Assistant(s) (COTAs), and a Program Compliance Monitor (PCM) completed a monitoring tool for the same individual. Speech Language Pathologists did not complete a POI monitoring form during this time period. The PCM then compared the therapists' answers to the PCM's answer for each question of the monitoring tool. If the therapist and the PCM's answers were the same, a score of 100% was documented showing 100% agreement. If the therapist and the PCM's answers were not the same, a score of 0% was documented. Inter-rater reliability scores were not calculated for the POI Monitoring forms submitted for May through September 2010. In October 2010, the POI Monitoring Tools for Section O documented a percentage indicating inter-rater reliability between the therapist and the PCM. An overall inter-rater reliability for the entire tool was also provided, along with an explanation of how many tools were completed. In addition, the issue of whether the therapist and PCM agreed that the Facility was in compliance with each question was indicated in the second column. An "S" for substantial compliance indicated this. The issue of agreement/disagreement between the therapist and PCM for the Facility's compliance was indicated in the third column. An "S" indicated the therapist did not score the Facility in compliance, however the PCM did. Twenty-six out of 52 answers documented agreement between the SLP and the PCM. An inter-rater reliability score of 50% was achieved for October POI Monitoring for Section O. The Plan of Correction stated: "instructions for monitoring tools have been completed. Therapists were to be in-serviced on instructions for monitoring tools on 11/17/10. Mitigation meetings were to be held in the beginning of December." The achievement of a defined inter-rater reliability threshold between the respective therapists and the PCM will be critical to ensure confidence with indicators that are scored as being compliant. The revision of indicator instructions and the provision of therapist re-training presented a sound approach to achieve inter-rater reliability. The Facility should continue to expand its self-assessment activities, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate, the monitoring tools, particularly to separate out the different types of reviews to be

	completed using different methodologies and samples; providing specific, written instructions on the implementation of the tools; training staff, who will conduct the monitoring, on the review tools and their implementation; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. During the entrance conference, the CCSSLC Habilitation Therapies Interim Director indicated that the Habilitation Therapy Department had implemented the following activities related to Section O following the previous compliance review: ▪ "PNMT members were designated to form both a 'core' and alternate team. Those teams include an RN, a PT, an OT, a Dietitian, and an SLP who have demonstrated competency in swallowing disorders. These members were chosen based on their training in physical and nutritional issues. The team meets twice a week on Tuesdays and Thursdays and has seen 15 high-risk individuals to date." ▪ "All members have been attending not only the webinars given by the state, but have attended private training off-campus such as Beckman-Oral Training."
	Summary of Monitor's Assessment: Significant progress had been made since the last compliance review in reference to the establishment of a PNM Team. A review of initial PNMT minutes, dated 7/30/10, indicated the purpose of the meeting was to discuss the assignment of Core PNMT members and the beginning process for the Core PNM Team. The minutes documented the presentation of a flow chart of the PNM Team process by the Assistant Director of Operations. The Core PNM Team members were identified as a Physical Therapist, occupational therapist, speech language pathologist, registered nurse and registered dietitian. The Chairperson of the Core PNMT was a Physical Therapist. Alternate PNM Team members were identified if Core PNM Team members were not available. The minutes further identified the issue of the subjectivity of the current rating system and it was determined that the Core PNMT would identify high-risk individuals according to criteria. To further delineate the Core PNMT process a policy was developed. The CCSSLC Physical and Nutritional Management Participating in PNMT Meetings Step-Down Policy O.2, approval date of 7/15/10, outlined the PNMT process. The current OT and SLP therapy and dietitian caseloads of the Core PNMT members will continue to significantly impact their ability to address adequately their responsibilities as Core PNMT members for individuals at the highest risk levels within the Facility, as well as provide supports to individuals on their respective caseloads. The Habilitation Therapies Director and staff had begun the process of analyzing the current staffing needs of physical therapy, occupational therapy, and speech language pathologists. Based on information provided, a formal analysis of caseloads for each discipline would be completed by July 2011. The importance of attendance by Core and Alternate PNMT members for PNMT-related continuing

	education webinars and outside courses must be non-negotiable. The absence of attendance documentation for Core PNMT and Alternate PNMT members for multiple PNMT courses was unfortunate. PNMT team members have a responsibility to participate in on-going, continuing education opportunities to expand their knowledge and skills, and ensure they are knowledgeable with regard to current trends within their respective fields as well as other team members' fields of expertise. The PNMT reviewed and assessed thirteen individuals who were identified at high risk, but this process did not consistently include all of the necessary components. For example, there was inadequate documentation of risk identification levels based upon physical and nutritional history; analysis or recommendations leading to the development of measurable, functional outcomes for individuals at highest risk to minimize and/or reduce the identified health risk; implementation strategies; documentation of competency-based training for individual strategies; a monitoring schedule for individuals at highest risk; or a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. The Habilitation Therapies Department had made progress in the development of a number of policies, protocols, and monitoring forms to support mealtime safety and implementation of PNMPs. These policies, protocols, and monitoring forms provided a strong foundation to support mealtime safety, but no evidence was submitted to document competency-based staff training for participants who were responsible for this mealtime safety initiative. Twenty-eight individual observations were completed of staff's implementation of dining plans and/or PNMPs. Overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or mealtime plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, etc. There appeared to be a misunderstanding of the concept of competency-based training for foundational PNS training as well as the provision of person-specific PNMP training. Competency-based training was documented as successful when staff verbalized back to the trainer what was required. Staff verbalization of a learned skill does not meet the standard of competency-based training. For example, to ensure staff competency in positioning and alignment, staff must demonstrate this skill. Habilitation Therapies was working with the Training Department, and the projected date for having updated foundational and refresher classes with competency-based training was July 2011. A review of Facility reports, including those from Quality Assurance, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis leading to the identification of potential issues, and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of, and/or frequency of, certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual-specific and systemic levels. This information should be integrated into the Facility's Quality Assurance, Incident Management

	and Risk Management systems. A component of the At-Risk Individuals policy required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition. The assessment is designed to reduce the incidence of aspiration pneumonia and its complications and to assess continued need for enteral eating." All individuals who were enterally nourished were to be evaluated using the evaluation format. CCSSLC identified 88 individuals who received enteral nutrition. Assessments/evaluations of these individuals were to be completed by 3/31/11. During the next on-site review, a record sample of individuals will be reviewed to determine the efficacy of the Aspiration Pneumonia Initiative for individuals who are enterally nourished.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional	Due to the multiple requirements included in this provision of the SA, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the SA, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The assessment and planning processes in which the team is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the SA. <u>The PNM team consists of qualified Speech Language Pathologist (SLP), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietician (RD), and, as needed, ancillary members [e.g., MD, Physician's Assistant (PA), Registered Nurse Practitioner (RNP)].</u> Significant progress had been made since the last compliance review in reference to the establishment of a PNM Team. A review of initial PNMT minutes, 7/30/10, documented the attendance of the CCSSLC Director, Assistant Director of Programs, Quality Assurance Program Auditor for Section O, P and R, two Physicians, a Nurse Practitioner, one Nurse, two Physical Therapists, two Occupational Therapists, one Certified Occupational Therapist Assistant, two Registered Dietitians, one Speech Language Pathologist, and two Residential Directors. The purpose of the meeting was to discuss the assignment of Core PNMT members and the beginning process for the Core PNM Team. The minutes documented the presentation of a flow chart of the PNM Team process by the Assistant Director of Operations. The Core PNM Team members identified a Physical Therapist, Occupational Therapist, Speech Language Pathologist, Registered Nurse, and Registered Dietitian. The Chairperson of the Core PNMT was the Physical Therapist. Alternate PNM Team members were identified if Core PNM Team members were not available. The	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	minutes further identified the issue of the subjectivity of the current rating system, and it was determined that the Core PNMT would identify high risk individuals based on criteria such as "respiration, nutrition, skin, for example." To further delineate the Core PNMT process a policy was developed. The CCSSLC Physical and Nutritional Management Participating in PNMT Meetings Step-Down Policy O.2, approval date of 7/15/10, outlined the following PNMT process: The purpose of the PNMT was to: ▪ Provide comprehensive assessment to individuals identified as being at an increase risk level that focused on nutritional health status, oral care, medication administration, proper alignment, positioning and nutritional intake; ▪ Make recommendations and provide treatment as appropriate; ▪ Provide training to staff in Physical Nutritional Management issues; and ▪ Other activities as appropriate. The PNMT program was comprised of four phases, including: ▪ Referral Phase-Risk Assessment; ▪ Comprehensive Assessment Phase; ▪ Treatment/Training Phase; and ▪ Review Phase. During the Referral Phase individuals identified at Risk Level 1-High would be referred to the PNMT for the completion of a comprehensive assessment and a treatment plan. A referral to the PNMT would require the following information to be submitted to the Core PNMT members for review: ▪ Significant lab findings; ▪ Aspiration-related respiratory infections; ▪ Emesis; ▪ Test/procedure results/recent surgery (current); ▪ Information on other significant medical problems; ▪ Medication print-outs, if needed; ▪ MBSS (recent), EGDs; and ▪ GI concerns (nursing information). The Comprehensive Assessment Phase involved the provision of a comprehensive assessment that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning, and nutritional intake. Evaluation procedures might include, but not be limited to: mealtime evaluations, videoesophagrams, other radiological procedures, esophagogastroduodenoscopy (EGD), lab work, skin assessment, mat assessment, wheelchair assessment, and nutritional	

#	Provision	Assessment of Status	Compliance
		assessment. The Treatment/Training Phase integrated assessment results and recommendations into the design of appropriate PNM support plans as outlined in Health Care Guidelines, Section VI and the Settlement Agreement requirements contained in Sections O.3 through O.8. The Review Phase involved the analysis and tracking of an individual's status regarding plan effectiveness and to minimize PNM risk indicators. Issues identified during the review were to be followed by the PNM Team and would remain open until all issues had been resolved and appropriate training was conducted. PNMT meetings were to be held twice a week, but also could occur: ▪ When feeding/health problems arose; ▪ After esophagrams/medical diagnostic tests were performed; ▪ Before final treatment decisions were made; ▪ To perform follow-up activities; and ▪ At any phase in the PNM procedure. The step-down policy acknowledged the following procedural steps for the PNMT process: Prior to the PNMT: ▪ Medical Program Specialist and/or Administrative Assistant to the Habilitation Therapy (HT) Director would send a list of individuals that would be reviewed in the next PNMT meeting to the Core Team members and the Personal Support Team (PST) of the individual to be seen; ▪ PNMT Core Members would familiarize themselves with the assessments that had been completed by the PST; and ▪ The PST of the individual that was to be reviewed would ensure that all assessments were up-to-date and filed in the Integrated Record. PNMT Meetings of Core Members would: ▪ Meetings were to be scheduled on Tuesdays and would be conducted prior to the meeting with the individual and the PST; and ▪ Core PNMT members would ensure that all assessments considered the following potentials for risk: aspiration, choking and pneumonia; need for specialized positioning; weight; alteration of diet texture; GI problems; risk of falling; circulatory issues; skin integrity; need for assistive equipment; head, trunk and pelvic positioning; optimum elevation for enteral nutrition; seatbelt position; use of lap trays and other therapeutic interventions that impact health	

#	Provision	Assessment of Status	Compliance
		and function.	

PNMT Meeting with the individual and PST members would:

- Be implemented on Thursday;
- Core PNMT members would perform comprehensive assessments and review their findings with the PST and individual, and make program recommendations to the PST for implementation;
- QMRP would document the results of the meeting in a Personal Support Plan Addendum (PSPA), which would include an action plan to track timely completion of the recommendations, as well as the date on which the individual would return to the PNMT; and
- Medical Program Specialist and/or Administrative Assistant to the HT Director would record the PNMT Meeting Minutes, and maintain them in the PNMT minutes folder in the shared folder.

The PST of the individual would ensure that recommendations were followed. During their monthly PSPA meetings and/or quarterly reviews, the PST was to document the efficacy of the PNMT recommendations.

A document entitled "Specific Roles of PNM Team Members," undated, identified the following discipline-specific roles of PNM Team members:

PNMT Member	Role
Physician	▪ Monitored individuals who were identified as at high risk and referred individuals to appropriate disciplines.
Occupational Therapist	▪ Performed evaluation of feeding/oral control and other nutrition-related assessments; ▪ Designed PNM programs including positioning/ handling, oral control/feeding techniques, and equipment; ▪ Trained staff; ▪ Monitored dining areas; and ▪ Conducted videofluorscopic and other procedures and met with consultants.
Physical Therapist	Performed assessment for proper alignment, seating and positioning, and other related assessments; ▪ Designed PNM programs including positioning/handling, mobility/transfer and equipment; and ▪ Trained staff.

#	Provision	Assessment of Status	Compliance
			

Registered Nurse	▪ Collected specific data related to concerns in individuals' health and diagnostic procedures to be reviewed; ▪ Monitored individuals for presence of specific pathology related to PNM; ▪ Ensured PNM programs were sufficient and were carried out in order to maintain good skin integrity, respiratory health, and normal elimination; and ▪ Trained staff.
Registered Dietitian	Evaluated individuals and collected specific data concerning diet, weight, intake, monitoring of medications, and lab values; • Monitored individual signs and symptoms of nutritional risk and efficacy of interventions; and • Trained food service staff.

In the section that addresses Section O.2 of the Settlement Agreement, the Monitoring Team's review of 13 individuals identified at high risk and assessed by the Core PNM Team since the last compliance review is discussed.

At the time of the review, the current CCSSLC census was 283 individuals. The following chart identified the current caseloads and/or responsibilities of the Core PNMT members:

Core PNMT Team Members	Current Caseloads and Responsibilities
Registered Nurse (RN)	CCSSLC Staff-to-individual ratio for nursing was 1 to 2.68
Physical Therapist (PT)	Chairperson of Core PNMT, no current caseload
Occupational Therapist (OT)	Supported 146 individuals
Dietitian (RD)	One of two dietitians on campus to support 283 individuals
Speech Pathologist (SLP)	Supported 146 individuals

Alternate PNMT Team Members	Current Caseloads and Responsibilities
Registered Nurse (RN)	CCSSLC Staff-to-individual ratio for nursing was 1 to 2.68
Physical Therapist (PT)	Supported 82 individuals

#	Provision	Assessment of Status	Compliance

Occupational Therapist (OT)	Supported 76 individuals
Dietitian (RD)	One of two dietitians on campus to support 283 individuals
Speech Pathologist (SLP)	Supported 136 individuals

At the time of the review, the OT and SLP therapy and dietitian caseloads of the Core PNMT members would significantly impact their ability to adequately address their responsibilities as Core PNMT members for individuals at the highest risk levels within the Facility, as well as provide supports to individuals on their respective caseloads. The Habilitation Therapies Director and staff had begun the process of analyzing the current staffing needs of physical therapy, occupational therapy, and speech language pathologists. Based on interview, a formal analysis of caseloads for each discipline would be completed by July 2011.

With regard to the qualifications of the Core PNMT members, review of CVs and/or resumes submitted for the PT, OT, and RD, documented each had five years of experience within their respective fields. CV and/or resumes were not submitted for the Core PNMT RN or SLP. Alternate PNMT member's CV and/or resumes documented the PT, OT, RD, and SLP had five years of experience within their respective fields. A CV and/or resume was not submitted for the alternate PNMT RN. The Core and Alternate PNMT PTs, OTs and SLPs had current licenses to practice in the state of Texas according to submitted documentation.

Two Occupational Therapists and two Speech Language Pathologists were registered for the Beckman Oral Motor Assessment and Intervention Protocol workshop on January 13 and 14, 2011 in Corpus Christi.

The following chart contains the list of continuing education courses submitted with the discipline-specific attendance for Core and Alternate PNMT members:

Continuing Education	Core PNMT Members	Alternate PNMT Members
Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management (6/16/10)	OT	OT, SLP
PNMT Seating/Positioning (7/1/10)		
Issues in Nutritional Management (7/7/10)	OT	SLP
PNMP and Wheelchair Clinic Webinar (7/7/10)	OT	
PNMT Risk/Development of Interventions (7/9/10)		
PNMT Risk/Development of Interventions II		

#	Provision	Assessment of Status	Compliance

(7/16/10)		
PNMP and Wheelchair Clinic Webinar (7/19/10)	OT	PT
PNMT Risk/Development Interventions III (7/23/10)		
PNMT Clinical Assessment Technologies and Wound Investigation Process (7/30/10)	PT, OT	PT
PNMT Identification of Risk and Development of Interventions (7/30/10)	PT, OT, RD	PT, OT, RD, SLP
Issues in Nutritional Management Part 2 (8/13/10)		SLP
PNMT and Wound Care Investigation (8/13/10)	PT, OT, RN	SLP
PNMT GI Webinar for OTs (8/17/10)		
Seating and Positioning for Dysphagia (9/1/10)	PT, OT, RD, SLP	PT, OT, RD, SLP
Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (9/20/10 through 9/22/10)		SLP
PNMT Core Introduction to PNMT (10/6/10)		
Competency-Based Training (10/27/10)		PT, SLP
20th Annual Habilitation Therapies Conference (9/20/10 to 9/21/10)	OT (10 CEUs),	PT (1.20 CEUs), OT (10.25 CEUs)
Texas Autism Conference (10/6/10 through 10/9/10)	OT (15 CEUs), SLP (15 CEUs)	SLP (15 CEUs)

Review of the clinical instruction completed by Core and Alternate PNMT members (RN, PT, OT, RD and SLP) revealed the following:

- One out of five (20%) Core PNMT and two out of five (40%) Alternate PNMT members attended Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management;
- None of five (0%) Core PNMT and none of five (0%) Alternate PNMT members attended the PNMT Seating/Positioning Webinar;
- One out of five (20%) Core PNMT and one out of five (20%) Alternate PNMT members attended Issues in Nutritional Management;
- None out of five (0%) Core PNMT and none out of five (0%) Alternate PNMT members attended the PNMT Risk/Development of Interventions I;
- None out of five (0%) Core PNMT and none out of five (0%) Alternate PNMT members attended the PNMT Risk/Development of Interventions II;
- None out of five (0%) Core PNMT and none out of five (0%) Alternate PNMT members attended the PNMT Risk/Development of Interventions III;

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		▪ Two out of five (40%) Core PNMT and one out of five (20%) Alternate PNMT members attended the PNMT Clinical Assessment Technologies and Wound Investigation Process; ▪ Three out of five (60%) Core PNMT and four out of five (80%) Alternate PNMT members attended the PNMT Identification of Risk and Development of Interventions; ▪ None out of five (0%) Core PNMT and one out of five (20%) Alternate PNMT members attended Issues in Nutritional Management Part II; ▪ Three out of five (60%) Core PNMT and one out of five (20%) Alternate PNMT members attended PNMT and Wound care Investigation ▪ None out of five (0%) Core PNMT and none out of five (0%) Alternate PNMT members attended PNMT GI Webinar for OTs; ▪ Four out of five (80%) Core PNMT and four out of five (80%) Alternate PNMT members attended Seating and Positioning for Dysphagia; ▪ None out of five (0%) Core PNMT and none out of five (0%) Alternate PNMT members attended PNMT Core Introduction to PNMT; ▪ None out of five (0%) Core PNMT and two out of five (40%) Alternate PNMT members attended Competency-based training; and ▪ One out of five (20%) Core PNMT and two out of five (40%) Alternate PNMT members attended the 20th Annual Habilitation Therapies Conference. The attendance of Core and Alternate PNMT members at related continuing education webinars and outside courses must be non-negotiable. The absence of Core PNMT and Alternate PNMT members at multiple PNMT courses was unfortunate. PNMT team members have a responsibility to participate in on-going continuing education opportunities to expand their knowledge and skills, and ensure they are knowledgeable of current trends within their respective fields, as well as other team members' fields of expertise. Team members should be held accountable to attend continuing education courses. <u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> The Core PNMT met on the following dates according to submitted documentation:	

Core PNMT Only Meeting Dates	**Core PNMT and PST Members Meeting Date**	**Individual PNMT Assessment with Core PNMT and PST Members**
August 10	August 12	Individual #246 Individual #284

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		(table and text below)	

August 17	August 19	Individual #160
August 24	August 26	Individual #43
August 31	September 2	Individual #348
September 7	September 9	Individual #173
September 14	Deferred due to hospital admission for Individual #320	
September 21	Deferred due to hospital admission for Individual #320	
September 28	September 30	Individual #320
October 5	Deferred due to contact isolation for Individual #58	
October 12	October 14	Individual #58
October 19	October 21	Individual #297
October 26	October 28	Individual #2
November 2	November 4	Individual #139
November 9		
November 16	November 18	Individual #153 Individual #207

Based on a review of 14 individual records (Individual #58, Individual #311, Individual #270, Individual #173, Individual #316, Individual #130, Individual #375, Individual #42, Individual #141, Individual #378, Individual #131, Individual #31, Individual #158, and Individual #113), for three of the 14 individuals (Individual #58, Individual #311, and Individual #173) (21%), documentation supported that the core PNM Team had met regularly to address change in status, complete a comprehensive assessment, implement recommendations and strategies, and review clinical data.

The individual record sample was drawn from lists of individuals identified at-risk based on the following criteria:

- Individuals who had Emergency Room visits;
- Individuals who had hospitalizations;
- PNM Team meeting minutes;
- Individuals with an active pressure ulcer within the last six months;
- Individuals with severe dysphagia;
- Individuals with chronic constipation or who experienced fecal impaction within the last six months;
- Individuals with unexplained weight loss or BMI ≤ 20;

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		▪ Individuals with BMI ≥ of 30; ▪ Individuals who experienced a choking incident requiring the abdominal thrust within the last six months; ▪ Individuals with a diagnosis of aspiration pneumonia; ▪ Individuals who had experienced significant falls related to transfers and/or ambulation; ▪ Individuals with chronic respiratory infections; ▪ Individuals with chronic dehydration; ▪ Individuals with a diagnosis of osteoporosis and/or osteopenia; ▪ Individuals who experienced a fracture; and ▪ Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care, and functional communication. The Core PNMT completed a comprehensive Physical and Nutritional Management Team Evaluation for Individual #58, Individual #311 and Individual #173. Additional information on these individuals is provided below with regard to Section O.2. Individual examples of where the Core PNM Team did not meet regularly to address change in status, review clinical data, develop a comprehensive assessment to identify measurable functional outcomes, provide staff competency-based training and monitor the efficacy of intervention strategy results included: ▪ Individual #270 was transported to the emergency room on 7/26/10 "due to having fever." He was admitted to the hospital on 7/26/10 with a discharge diagnosis of UTI and pneumonia. A second hospital admission occurred on 10/1/10, with a discharge diagnosis of aspiration pneumonia. A document entitled "Individuals Diagnosed with Pneumonia Between 11/1/09 and 11/16/10" revealed Individual #270 was diagnosed on 5/27/10 with aspiration and on 10/1/10 with bacterial pneumonia. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identify complex physical and nutritional support needs. ▪ Individual #130 was hospitalized on 11/4/10, with a discharge diagnosis of pneumonia, and a UTI. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identify complex physical and nutritional support needs. ▪ Individual #42 was identified at high risk for falls on 10/20/10. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identify complex physical and nutritional support needs. ▪ Individual #141 was identified at high risk for osteoporosis on 10/19/10. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identify complex physical and	

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		nutritional support needs. ▪ Individual #378 was identified at high risk for chronic respiratory infections and pneumonia on 10/19/10. She was hospitalized on 7/27/10 with a discharge diagnosis of pneumonia and ileus. Another hospitalization occurred on 8/20/10 with a discharge diagnosis of pneumonia. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identify complex physical and nutritional support needs. ▪ Individual #131 was identified at high risk for choking on 8/17/10. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identify complex physical and nutritional support needs. ▪ Individual #158's Nutritional Evaluation, dated 12/16/10, documented his "BMI 49.5 [Body Mass Index] (normal 20-25). An ideal body weight range (IBWR) is 145-180lbs based on Body Mass Index Chart. This means [Individual #158] is 175 lbs (or 97%) above his IBWR [Ideal Body Weight Range] at the present time and is considered severely obese (Grade III). [Individual #158's] weight has gradually increased over the past year from 342-367lbs with a net gain of 13lbs since his last staffing." Individual #158 was identified at high risk for weight gain on 10/21/10. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identify complex physical and nutritional support needs. A review of the individuals who were admitted to the hospital with a discharge diagnosis of aspiration pneumonia and/or pneumonia, outside of the individual record sample described above, revealed none of the following 15 individuals (0%) were reviewed by the Core PNMT: Individual #161, Individual #223 (received enteral nutrition), Individual #179 (received enteral nutrition), Individual #89 (received enteral nutrition), Individual #142 (received enteral nutrition), Individual #256 (received enteral nutrition), Individual #49 (received enteral nutrition), Individual #113 (received enteral nutrition), Individual #180 , Individual #124 (received enteral nutrition), Individual #305, Individual #312, Individual #351, Individual #221, and Individual #198. Eight of these 15 individuals received enteral nutrition, which placed them at high risk for aspiration pneumonia.	
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	<u>A process is in place that identifies individuals with PNM concerns.</u> PNMT Minutes, dated 7/30/10, described the process the Core PNMT would utilize until the State-approved Risk System was finalized and implemented. They stated: "The PNM Core Team will identify the High Risk Individuals based on certain criteria such as respiration, nutrition, skin, for example. It was mentioned that some people with behavioral considerations would not be considered High Risk nor would all individuals coming out of the hospital. However, i.e., someone with cardiac problems and other	Noncompliance

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	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.	medical indicators (respiratory problems, swallowing problems, skin, and nutrition) would qualify." The Core PNM Team criteria was defined in the PNMT minutes dated 8/5/10 as: ▪ Aspiration; ▪ Choking; ▪ Respiratory; and ▪ Medical concerns. Since the last compliance review, the Core PNMT reviewed the following 15 individuals: Individual #246, Individual #284, Individual #160, Individual #43, Individual #348, Individual #173, Individual #320, Individual #58, Individual #297, Individual #2, Individual #139, Individual #153, Individual #207, Individual #311, and Individual #247. Individual #311 and Individual #247's PNMT Evaluations had not been finalized. Individual #247's PNMT Evaluation was held on 1/6/11, during the week of the on-site review. Based on documentation provided, "a preliminary assessment of our census indicated an inaccurate number of high-risk individuals. Recently, the new risk policy came out (in draft form) and these numbers are being stabilized. We [Core PNMT] have already begun to complete comprehensive assessments on multiple high-risk individuals; however, all individuals who have been identified as needing an evaluation have not yet received assessment. The target date for completion of these assessments will be January 2012." Thirteen individuals were identified at high risk, and reviewed and assessed by the Core PNMT. For certain indicators, a subset of the record sample was selected. For these indicators, the individuals within the record subset are identified at the end of the indicator. This risk identification and assessment process, as defined in the step-down policy, did not consistently include adequately defined processes, as illustrated by: ▪ In none of the 13 records reviewed (0%), there was documentation of risk identification levels based upon physical and nutritional history, current status, and specific criteria for guiding placement of individuals in specific risk levels. ▪ In 13 of the 13 records reviewed (100%), there was documentation of a comprehensive assessment. ▪ In none of the three records in the subset (Individual #246, Individual #284, and Individual #320) (0%) did the comprehensive assessment, the PNMT completed, include an analysis providing a rationale for the development of measurable, functional outcomes for individuals at highest risk to minimize and/or reduce the identified health risk. ▪ In 10 of 13 records reviewed (77%) a PSP Addendum for the PNMT meeting was present. Individual #207, Individual #246, and Individual #284 did not have a	

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		PSP Addendum for the Core PNMT meeting. ▪ In none of the two records in the subset (Individual #160 and Individual #173) (0%) was there documentation of development of implementation strategies. ▪ In none of the two records in the subset (Individual #2 and Individual #139) (0%) was there documentation of competency-based training for individual strategies. ▪ In none of the two records in the subset (Individual #297 and Individual #153) (0%) was there documentation of a monitoring schedule for individuals at highest risk. ▪ In none of the 13 records reviewed (0%) was there documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. The Monitoring Team reviewed the 13 individuals the Core PNMT and PST assessed, and identified the following issues: ▪ Individuals the Core PNMT reviewed had Health Risk Assessments completed, but these assessments did not provide specific criteria for guiding the placement of individuals in specific risk levels. In the absence of a State-approved risk assessment, the PNMT minutes dated 7/30/10 discussed the absence of a "good Risk System," and stated the PNM Core Team would identify high-risk individuals based "on certain criteria such as respiration, nutrition, and skin." Based on interview, the Risk Guidelines-Draft, dated 12/14/10, would be completed for all individuals. Based on the Risk Guidelines "within 30 days of admission of an individual to the Facility, upon changes in status, and at least annually thereafter, the responsible interdisciplinary team members will complete risk assessments for the individual to determine areas of risk." The Core PNMT members, in collaboration with PST members, were completing Risk Guidelines for Individual #247 during the Core PNMT and PST meeting on 1/5/11 during the week of the on-site review. The Facility's implementation of Risk Guidelines will be reviewed further during the next on-site compliance review. ▪ Individual #246's PNM Team Evaluation, dated 8/12/10, stated he was referred for PNMT assessment due to aspiration, dysphagia, and GI concerns. His measurable outcomes were: "[Individual #284] to verbalize signs/symptoms esophageal stricture/webbing and his diet texture with no prompting and [Individual #284] to be able to walk around dorm with use of rolling walker." The analysis section of the PNMT Evaluation identified the following issues with summary statements: esophageal stricture/webbing, 11 pound weight loss, poor dentition, left hip pain, and poor posture in current seating system. There should be a direct correlation between information presented in the analysis section related to the identified health risk indicators for the individual and how	

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		these risk indicators will be minimized and/or the identified health risk(s) reduced. Although there was some correlation, for example, increasing his independence with his diet related to the esophageal stricture/webbing, other identified risk factors were not addressed at all. ▪ Individual #284's PNMT Evaluation dated 8/12/10 stated she was referred to the PNMT for aspiration, chronic respiratory illnesses, and medical concerns. Her measurable outcome was "decrease hospitalization to 1 and infirmary admission to 4 or less within 12 months." This outcome did not distinguish how her identified health-risk indicators of aspiration, chronic respiratory illnesses and medical concerns would be addressed to minimize and/or reduce them. Furthermore, Individual #284 was hospitalized on 10/26/10, and was discharged on 11/8/10, with a diagnosis of pneumonia. Per documentation, the Core PNMT minutes, dated 8/17/10, provided a follow-up to Individual #284's recommendations, but there was no further review documented in PNMT minutes of Individual #284 post-hospitalization. ▪ Individual #320's Core PNMT Evaluation, dated 9/30/10, stated: "Placement of G-tube in 3/11/10 seems effective in preventing Aspiration Pneumonia as evidenced by no treatment required for pneumonia since then." However, Individual #320 was hospitalized on 9/15/10 with a discharge diagnosis of UTI and pneumonia. According to documentation submitted, he was hospitalized again on 11/16/10 with a discharge diagnosis of GI bleeding, anemia, and mild gastritis, but his death was reported as 11/16/10. His Measurable Outcomes were: 1) Wheelchair Department will complete modification of the wheelchair seat by 10/7/10; 2) Pressure mapping of the wheelchair will show no pressure points by 10/17/10; 3) Monitoring will show 100% compliance on positioning and PNMP Equipment (pressure relieving mattress) by 10/30/10; and 4) monitoring will show 100% compliance on diet recommendations by 12/1/10. A review of the Comprehensive Assessment showed it did not discuss an assessment of his current positioning within his residence and other natural environments. A review of the analysis section of the PNMT evaluation did not provide a rationale for the recommendations. ▪ Individual #207's PNMT Evaluation, dated 11/18/10, analysis section did not provide rationale for some of her PNMT recommendations. For example, a recommendation stated: "dietary consult due to history of meal refusals, spillage of food and fluids, and spitting out medications. She also has frequent problems with constipation." However, there was no recommendation for the Core PNMT members to assess her during mealtimes and medication administration to determine if her PNMP and Dining Plan strategies continued to be appropriate, and if staff were competent to implement the PNMP strategies. ▪ Individual #160's Comprehensive Assessment, dated 8/19/10, and subsequent documentation, did not identify implementation strategies for achievement of	

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		identified recommendations and/or measureable outcomes. ▪ Individual #173's PNMT Evaluation, dated 9/9/10, and subsequent documentation, did not identify implementation strategies for achievement of identified recommendations and/or measureable outcomes. For example, Individual #173 was referred to the Core PNMT for respiratory issues, aspiration, and UTI's. His recommendations were to: 1) complete modifications to his wheelchair; and 2) increase Individual #173's participation in his environment through sensory stimulation. His measurable outcomes were to lower his risk level from high to medium, and to not have any hospital/infirmary admissions in the next four months. There were no implementation strategies identified for his second recommendation. Furthermore, it was unclear how the second recommendation and the outcomes proposed addressed his high-risk levels for aspiration pneumonia. ▪ Individual #2's PNMT Evaluation, dated 10/28/10, and subsequent documentation did not document competency-based staff training on the revision of the PNMP schedule for position changes and alternate positioning. ▪ In Individual #139's PNMP Evaluation, dated 11/4/10, measurable outcomes were: 1) a revised PNMP will be completed by 11/11/10; 2) PT/OT will complete an assessment update; 3) updated Health Management Plan for oral care; 4) vocational assessment will be done; 5) dietary recommendation will be implemented; 6) osteoporosis treatment to be considered; and 7) follow-up meeting to assess outcomes by 11/16/10. No competency-based staff training documentation was submitted related to these recommendations. ▪ Individual #297's PNMT Evaluation, dated 11/16/10, did not provide an analysis, recommendations and/or measurable outcomes. As a result, there was no monitoring schedule identified to ensure compliance, as well as determine the efficacy of the Core PNMT recommendations. ▪ Individual #153's PNMT Evaluation, dated 11/18/10, did not identify a monitoring schedule to ensure compliance with, as well as determine the efficacy of the following Core PNMT recommendations: 1) PNMP will reflect medication administration with pudding; 2) staff will be trained for Aspiration Precautions and Feeding Techniques; and 3) staff will be in-serviced in Individual #153's dining room hours. The Core PNMT should consider the following recommendations to support successful implementation of the PNM process for those individuals at highest risk with complex health, physical, and nutritional support needs: ▪ Review completed Risk Guidelines for individuals referred to the Core PNMT to determine if appropriate risk levels have been assigned; ▪ Complete an assessment to determine the status of safe positioning for an individual within natural environments (nighttime positioning, seating system,	

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		bathing, tooth brushing, classroom, work, leisure, medication administration, etc.) to determine the efficacy of current PNMP strategies, including staff instructions, prior to the Core PNMT and PST meeting; ▪ Identify individual triggers for identified risk indicators, such as aspiration pneumonia, and integrate these triggers into relevant working plans, such as the PNMP, Dining Plan, BSP, Nursing Care Plan, etc.; ▪ Ensure the assessment provides clinically justified techniques for mealtime (including individuals who were enterally nourished), oral care, bathing, dental appointments, bedtime positioning, medication administration, etc.; ▪ Develop an individual-specific action plan format to track completion of recommendations. This should be incorporated into the PSP; ▪ Include, in the analysis section of the PNM Evaluation, assessment data, which provides justification and rationale for the recommendations. The analysis should provide a correlation between the identified high-risk indicators that resulted in referral to the Core PNMT and the recommendations; ▪ Include, in the recommendations and measurable outcomes, criteria to measure the efficacy of the interventions; ▪ Develop implementation strategies to ensure recommendations and measureable outcomes are implemented; ▪ Ensure staff complete performance check-offs to document staff competency for identified skills for those individuals at highest risk; ▪ Develop simple methods to document, monitor, and track clinical objective data to support the effective implementation of recommendations; ▪ Implement a mechanism to report a change in an individual's status to the Core PNMT to enable the Core PNMT to evaluate the plan and/or make modifications to the plan; and ▪ Develop a person-specific monitoring plan for the Core PNM Team to complete. This should be correlated to PNM recommendations and measurable outcomes enabling the Team to quickly determine the efficacy of identified implementation strategies. <u>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day, and during nutritional intake.</u> A review of records of 11 individuals who had been identified by the Facility at high risk for skin breakdown/decubitus ulcer, falls, osteopenia/osteoporosis, chronic respiratory infections/pneumonia, choking, a BMI score greater than 30 or less than 20, and/or had been hospitalized with a diagnosis of aspiration pneumonia and/or pneumonia (including Individual #270, Individual #316, Individual #130, Individual #375, Individual #42, Individual #141, Individual #378, Individual #131, Individual #31,	

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		Individual #158, and Individual #113) revealed the following: ▪ In none of the 11 records reviewed (0%) was documentation found of PNMT review/analysis of the findings of relevant discipline-specific assessment(s), including but not limited to PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. Such a summary should have addressed: o Physical health status; o Nutritional health status; o Oral care; o Medication administration; o Mealtime strategies; o Proper alignment; and o Positioning during the course of the day and during nutritional intake. • In none of the 11 records reviewed (0%), measurable, functional outcomes were identified. • In none of the 11 records reviewed (0%) was documentation found of PNMPs developed with input from the PNM (NMT) for those individuals at highest risk. • In none of the 11 records reviewed (0%) was congruency found between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. • In none of the 11 records reviewed (0%) were comprehensive summary results integrated into the design of the appropriate PNM support plans as outlined in HCG VI and VIII and SA O.3 through O.8. • In none of the 11 records reviewed (0%) were PNMT updates provided as needed until the individual was discharged from the PNMT. Additional individual examples are provided in the section that addresses Section O.1 of the Settlement Agreement.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> A review was conducted of 26 individuals identified at high risk, including: (Individual #270, Individual #316, Individual #130, Individual #375, Individual #42, Individual #141, Individual #378, Individual #131, Individual #31, Individual #158, Individual #113, Individual #246, Individual #284, Individual #160, Individual #43, Individual #348, Individual #173, Individual #320, Individual #58, Individual #297, Individual #2, Individual #139, Individual #153, Individual #207, Individual #247, and Individual #311) The record review included review of a PNMP. Although many of the components	Noncompliance

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	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.	of a PNMP were present for these individuals, there were a number of components missing. More specifically: ▪ In 26 of 26 records reviewed (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 26 of 26 records reviewed (100%), transfer instructions were included. ▪ In 26 of 26 records reviewed (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks and/or addressed receiving nutrition through a feeding tube. ▪ In 26 of 26 records reviewed (100%), the mealtime/dining plan included food/fluid textures and/or addressed receiving nutrition through a feeding tube. ▪ In 10 of 26 records reviewed (38%), the time that an individual needed to remain upright after eating and/or receiving enteral nutrition was identified. ▪ In 26 of 26 records reviewed (100%), the mealtime/dining plan included behavioral concerns related to intake and/or addressed receiving nutrition through a feeding tube. ▪ In five of 26 records reviewed (19%), strategies for medication administration were included. ▪ In 19 of 26 records reviewed (73%), strategies for oral hygiene were included. ▪ In 26 of 26 records reviewed (100%), individual adaptive equipment was included. ▪ In 24 of 26 records reviewed (92%), bathing/showering positioning and related instructions were included. ▪ In 26 of 26 records reviewed (100%), personal care instructions were included. ▪ In 26 of 26 records reviewed (100%), communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included: ▪ According to the Settlement Agreement, PNMPs need to incorporate strategies for medication administration, bathing/showering, and oral care for those individuals identified at risk. ▪ In addition, these PNMP strategies need to be integrated within an individual's nursing care/healthcare plan to support nurses during medication administration, as well as other procedures requiring attention to positioning and presentation techniques. ▪ In addition, the PNMP should identify the amount of time that an individual should remain upright after eating and/or receiving enteral nutrition. As noted above, such strategies were not consistently included in the PNMPs reviewed above. Based on interview, Habilitation Therapies had begun the process to modify PNMPs to include the above-mentioned strategies with a projected completion date of January 2012.	

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		PNM plans were incorporated into individual's Personal Support Plans. In 26 records reviewed (Individual #270, Individual #316, Individual #130, Individual #375, Individual #42, Individual #141, Individual #378, Individual #131, Individual #31, Individual #158, Individual #113, Individual #246, Individual #284, Individual #160, Individual #43, Individual #348, Individual #173, Individual #320, Individual #58, Individual #297, Individual #2, Individual #139, Individual #153, Individual #207, Individual #247, and Individual #311), none of the PNMPs (0%) were incorporated into individual Personal Support Plans. Information from PNMP should have been integrated within the PSP, not simply referenced and/or listed. Examples of where individual PNMPs were not incorporated in PSPs included: ▪ Individual #270's PNMP, dated 1/10/11, included a "Physical Focus: Prevent fractures from brittle bones and prevent further joint contractures" and a "Nutritional Focus: To identify, treat and monitor digestive problems." However, the physical and nutritional focuses did not address his high risk for aspiration pneumonia. The PNMP did not address his individualized triggers for aspiration pneumonia. He was hospitalized on 7/26/10, and discharged on 8/8/10, with a discharge diagnosis of UTI and pneumonia. He was hospitalized again on 10/1/10, and discharged on 11/5/10, with a discharge diagnosis of aspiration pneumonia. The PSP Addendum (PSPA), dated 11/10/10, stated "no changes in PNMP needed at this time." There were no therapists present for the PSPA. It was unclear why there were no changes to the PNMP to address his recurrent hospitalizations and infirmary admissions for pneumonia. ▪ Individual #378 was identified at high risk for chronic respiratory infections and pneumonia. She was hospitalized on 8/12/10, and discharged on 8/20/10, with a diagnosis of pneumonia. There were no Habilitation Therapy Consultations to re-assess her PNMP post-hospitalization. There was no documentation of a PSPA to address her hospitalization and discuss the status of her PNMP. PNMPs are developed with input from the PST, home staff, medical and nursing staff. In seven records reviewed (Individual #270, Individual #141, Individual #378, Individual #131, Individual #31, Individual #158, and Individual #113), none (0%) of the PNMPs were developed with input from the PST with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Moreover, therapists needed to be, but were not available during the Personal Support Plan annual meetings to present the rationale for PNMP strategies. This is discussed in further detail with regard to Section F.1.b. Examples of where individual PNMPs were not developed with input from the IDT included: ▪ Individual #158's PSP, dated 1/5/10, included recommendations to "continue	

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		with PNMP," but the PNMP did not address his high risk related to his weight. The PSP signature sheet did not document the attendance of an OT, PT, RD and/or SLP to discuss strategies to address his weight status. ▪ Individual #141's PSP, dated 1/22/10, stated "[Individual #141's] PNMP to continue." There was no PSP signature sheet attached to the PSP to document the attendance of an OT, PT, RD, and/or SLP to address the current strategies of her PNMP. ▪ Individual #131's PSP, dated 9/14/10, in the Assessments/Services the Person Uses/Needs section, the following statement related to the PNMP was included: "Continue PNMP Plan to maintain current ambulation and transfer skills, and minimize the likelihood of complications from G-tube feedings through positioning." There was no signature sheet attached to the PSP to document the attendance of an OT, PT, RD, and/or SLP to address the current strategies of his PNMP. ▪ Individual #31's PSP, dated 3/1/10, stated: "Continue to implement PNMP and update as needed." There was no signature sheet attached to the PSP to document the attendance of an OT, PT, RD, and/or SLP to address the current strategies of his PNMP, or to discuss the rationale for the PNMP strategies, and ensure the integration of these strategies across multiple disciplines. <u>PNMPs are reviewed annually at the PSP meeting, and updated as needed.</u> In none of seven records reviewed (0%), PNMPs were reviewed annually at the PSP meeting, updated as needed and integrated within the PSP. As discussed above, there was no evidence that the PNMPs were actually reviewed at the PSP meetings, particularly for those individuals for whom habilitation therapies staff were not present to meaningfully review the PNMPs. Without such review, they were not adequately integrated across disciplines, and recommendations from other assessments and/or team members were not incorporated into the plans. <u>PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results.</u> In none of six records reviewed (Individual #130, Individual #270, Individual #378, Individual #131, Individual #141, and Individual #158) (0%) were PNMPs reviewed and updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results. For example: ▪ Individual #130 was hospitalized on 11/4/10, and released on 11/9/10, with a discharge diagnosis of pneumonia and UTI. His PNMP, dated 8/4/10, was not revised to address his recent hospitalization for pneumonia. ▪ Individual #270 was hospitalized multiple times for pneumonia (1/2/10, 2/17/10, 3/26/10, and 4/30/10). His PNMP was not revised to address his high risk for aspiration pneumonia and./or include the identification of	

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		individualized triggers for staff to observe. ▪ Individual #378 was hospitalized on 7/27/10, and 8/12/10, with a discharge diagnosis of pneumonia. Her PNMP was revised on 8/25/10, but the physical and/or nutritional focus did not address her risk for aspiration pneumonia. The PNMP did not identify her individualized triggers for aspiration. ▪ Individual #131 was identified at high risk for choking on 8/17/10. His PNMP, revised on 9/14/10, did not address this identified risk. ▪ Individual #141 was identified at high risk for osteopenia/osteoporosis on 10/19/10. Her PNMP did address this risk. ▪ The Physical Focus of Individual #158's PNMP, dated 12/29/10, stated: "to maintain GERD precautions and reduce risk of injury." His Nutritional Evaluation, dated 12/16/10, revealed: "This means [Individual #158] is 175 lbs (or 97%) above his IBWR [Ideal Body Weight Range] at the present time and is considered severely obese (Grade III)." Individual #158 was at risk for multiple health concerns. His PNMP did not address his weight risk status, nor did it address strategies for weight loss. The following identifies the health risks associated with this level of obesity: "Persons 45.4 kg (100 lb) or more above desirable weight have exponential increases in mortality and serious morbidity compared with normal persons. The presence of a complication or an independent coronary risk factor along with obesity increases the mortality further. Among the 'threshold conditions' that appear at a critical level of body weight (60% or more above desirable weight), the most important are sudden unexplained death, ventilatory disorders, circulatory congestion, and functional limitations in activities of daily living. Recent epidemiologic data on extreme obesity and data on cardiac dysfunction show impaired quality of life in young, morbidly obese patients." (Morbid Obesity and Related Health Risks, John G. Kral, MD, Ph.D.)	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> Habilitation Therapies had made progress in the development of the following policies, protocols, and monitoring forms to support mealtime safety and implementation of PNMPs: ▪ Ensuring Safe Practices During Meals, P.5, approved on 11/15/10 and implemented 12/15/10; ▪ Safe Mealtime Practices Protocol, P.5.1, implemented 12/15/10; ▪ Documenting Meal Monitoring, P.4, approved on 11/15/10 and implemented on 12/15/10; ▪ Mealtime Monitoring Drill, implemented 12/15/10; ▪ Competency-Based Monitoring for Staff, revised 11/15/10; ▪ Person-Specific Monitoring in Dining Room, revised 11/15/10; and	Noncompliance

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		▪ Training Staff on Physical Nutritional Management Plans, approved on 11/8/10 and implemented on 12/8/10. The Ensuring Safe Practices During Meals policy presented the following steps: ▪ At the beginning of shift the Home Team Leader or Designee assigns Direct Care Professional (DCP) staff to act as the Home Dining Supervisor (HDS) and Dining Room Transporter (DRT) for each meal during the shift. ▪ Prior to the meal, the HDS goes to the dining room and sets up their assigned tables according to the Safe Mealtime Practices Protocol. ▪ When Food Service indicates the meal is ready to be served, the HDS calls the residence and informs the DRT(s) to start bringing the individuals to the dining room according to the Dining Schedule. ▪ The HDS is responsible for giving the Diet/Dining Card to the food service worker as individuals arrive in the dining room. ▪ The HDS is responsible for verifying the meal has been served according to the instructions on the Diet/Dining Card (diet order, texture, consistency, adaptive equipment, etc.), and gives the meal to the DRT. ▪ The DRT is responsible for verifying the meal has been served according to the instruction on the Diet/Dining Card (diet order, texture, consistency, adaptive equipment, etc.). ▪ The DRT, as needed, assists the individual with their meal as specified on the Diet/Dining Card and the Safe Mealtime Practices Protocol. This includes the use of Simple-Thick, Fiber-iffic and Beneprotein. ▪ During the meal, the HDS is available to assist the DRT(s) as needed so that the DRT(s) are able to remain at the table to assist the individual. The HDS uses the Mealtime Monitoring Drill as a guide. ▪ The Dining Room Monitor (DRM) is available in the dining room to ensure the meal runs smoothly; the Diet/Dining Cares and the Safe Mealtime Practices Protocol are being followed, and assists the HDS(s) and DRT(s) as needed. They are to complete one Mealtime Monitoring Drill per meal. ▪ At the end of each individual's meal, the DRT(s) returns the individual to the residence and brings the next individual for his/her meal. ▪ At the complete end of the meal, the HDS(s) clears the table(s) and puts away the condiments, supplements, etc. The Safe Mealtime Practices Protocol defined the duties of the Home Dining Supervisor, Dining Room Transporter, and Dining Room Monitor. The Documenting Meal Monitoring policy set forth the following responsibilities: ▪ Habilitation Therapies Director will create and maintain the Meal Monitoring Assignment by residence. This person assigns specific individuals to each	

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		designee based on current risk level. This will be re-organized every six months, in January and July.
		▪ Discipline Coordinator ensures that each designee received a copy of their assigned individuals.
		▪ Habilitation Therapies Department will ensure that all individuals are monitored at least once on a monthly basis.
		▪ Habilitation Therapies Director reports any missing paperwork to the appropriate discipline coordinator, Assistant Director of Programs (ADOP), and Facility Director.
		▪ Discipline Coordinator ensures that the designees are available to monitor one breakfast, one lunch, one supper, one snack, and one medication administration as outlined in this procedure.
		▪ Responsibilities also were defined for assigned monitoring staff, including the QMRP Coordinator, Chief Nurse Executive, Habilitation Therapies Director, Unit Director, Data Entry Clerk and Quality Assurance Director.
		
		The Training Staff on Physical Nutritional Management Plans identified the following steps:
		▪ The PST approves the PNMP during admission, 30 day-post admission, annual and addendum PSP, if needed.
		▪ On the same day the PST meets and approves the PNMP, the Habilitation Staff or PNMP Coordinator:
		  o Prints one copy of the PNMP with the training sheet on the back;
		  o Trains the residence team leader or designee and the staff responsible for implementing the PNMP;
		  o Takes the old PNMP from the Personal Support Book; and
		  o Places the new PNMP, with the attached training sheet, in the Personal Support Notebook.
		▪ The staff that has direct contact responsibilities for implementing the PNMP will ensure that they have been trained on the individual's PNMP and that their signature is located on the back of the PNMP before assuming responsibility for the individual.
		▪ Staff signature on the back of the sign in sheet indicates that they will read the PNMP throughout the day and ensure that all instructions are followed as prescribed.
		▪ The day/residential coordinator and PNMP coordinator randomly check the PNMP of individuals assigned to his/her residence throughout the day to ensure staff working with the individuals have been trained on the individual PNMP.
		▪ The staff responsible for carrying out the PNMP will not transfer their responsibility to another employee unless that staff has already been trained by the home team leader (or designee), HT staff, PNMP Coordinator, Psychologist,	

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		Psychological Assistant, QMRP, RN Case Manager, Residential Coordinator, Unit Coordinator, Home Team Leader, Campus Coordinator, Infirmary RN, EDO (Evening Duty Officer), and/or Unit Director. ▪ The staff accepting the responsibility for carrying out the PNMP must not accept the responsibility unless he/she has already been trained by the home team leader (or designee), HT staff, PNMP Coordinator, Psychologist, Psychological Assistant, QMRP, RN Case Manager, Residential Coordinator, Unit Coordinator, home team leader, campus coordinator, Infirmary RN, EDO, and/or Unit Director. These policies, protocols, and monitoring forms provided a strong foundation to support mealtime safety. However, no evidence was submitted to document competency-based staff training for participants who were responsible for this mealtime safety initiative. The Monitoring Team was not able to conduct observations in the Pacific Unit as the building was under quarantine. Twenty-eight individual observations were completed of staff's implementation of dining plans and/or PNMPs in other residences on campus. Overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or mealtime plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, etc. The following provides additional details regarding the observations: ▪ In two of nine observations (22%), staff were following mealtime plans. ▪ In zero of six observations (0%), staff were following positioning instructions while individuals were receiving enteral nutrition. ▪ In zero of seven observations (0%), staff were following wheelchair positioning instructions. ▪ In zero of two observations (0%), staff were following alternate positioning instructions. ▪ In zero of one observation (0%), staff were following transfer instructions. ▪ In zero of three observations (0%), nursing staff were following the PNMP to include diet texture/fluid consistency, positioning instructions, and use of appropriate adaptive equipment for medication administration. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: ▪ Individual #366's Dining Plan required the use of a plate guard, which was not being utilized properly. The staff member was presenting large bites and not giving a sip of fluid after every two to three spoonfuls as prescribed in the dining plan.	

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		▪ Individual #314's Dining Plan instructions were "to keep his chin down by presenting food at midline and below mouth/chin level." Staff were not following these instructions during the meal. ▪ Individual #348 Dining Plan instructions stated: "pour only small amounts (one to two sips in her glass at a time). Replenish fluids in small amounts only." Staff were not following fluid instructions. Individual #348 was presented with a full glass of fluid. Her wheelchair was not titled per instructions. Her footrests were not down on her chair, and her feet were dangling, which did not provide her with optimal support. ▪ Two staff using a mechanical lift transferred Individual #15. Staff did not support her head and the transfer moved too quickly. ▪ Individual #77, Individual #240, Individual #205, Individual #2, Individual #327, and Individual #64 were not positioned in optimal alignment and support in their seating systems while receiving enteral nutrition. ▪ Individual #25's PNMP affirmed: "use most upright position in wheelchair or bed when eating with G-tube," but did not give positioning instructions for receiving medication. The nurse administering his medication did not refer to his PNMP, nor was his chair in the most upright position. The Monitoring Team asked the Nurse Educator to see if the chair was in the most upright position. She was able to bring the chair into the most upright position. ▪ Individual #284's Dining Plan acknowledged: "when [Individual #284] is receiving nutrition via G-tube in the w/c, position her in an upright position." The nurse did not refer to the PNMP during the administration of her medications via the G-tube. Based on interview, PNMPs had been integrated into the medication administration record, or Med Ex, but the Monitoring Team did not detect this during observation(s) of medication administration. Nursing staff, in collaboration with Habilitation Therapies staff, should establish a system to ensure PNMPs are integrated in medication administration records as well as nursing care/healthcare plans to minimize identified risk factors for individuals. The Monitoring Team's observation of a Home Dining Supervisor in a dining area did not indicate that the supervisor was competent to provide coaching, mentoring, and monitoring of the staff during mealtimes as documented in mealtime examples above. Specifically, during the observation, the Home Dining Supervisor did not intervene to correct position and alignment, or model for staff the correct techniques when dining instructions were not being followed.	
O5	Commencing within six months of the Effective Date hereof and with	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u>	Noncompliance

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	full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Multiple staff training sheets were submitted that stated: "Training is competency-based. Staff must be able to demonstrate competency before 'passing' training." There appeared to be a misunderstanding of the concept of competency-based training for foundational physical and nutritional support (PNS) training, as well as the provision of person-specific PNMP training. Competency-based training was defined as "passing" when staff verbalized back to the trainer what was required. Staff verbalization of a learned skill does not meet the standard of competency-based training. For example, the Monitoring Team observed multiple individuals who were not in optimal alignment and support in their seating systems, which led the Monitoring Team to the conclusion that staff were not competent in positioning individuals in optimal alignment and support in their seating systems and/or alternate positions, or that they did not understand the importance of it, which should be a component of the training. To ensure staff competency in positioning and alignment, staff must demonstrate this skill. The primary characteristic of competency-based training, in the area of PNS, is staff should be required to demonstrate a learned skill rather than checking off that they have received training, verbalizing the concept, and/or completing a written test. Competency-based training should identify learning objectives/outcomes that define what a staff person must do, and provide the opportunity for staff to demonstrate the mastery of the learned skill. Prior to the introduction of competency-based training, traditional training usually consisted of attending a training course and successfully passing a written post-test. Competency-based training ensures each participant actually is able to perform a task/skill with defined criteria for determining when a staff member is deemed competent. Review of the Facility's training curricula revealed that it did not include adequate PNM training in the following areas: ▪ Generic and individual-specific mealtime risk triggers that alert staff to problems, and what staff were to do if these triggers were observed; ▪ Techniques to promote independence and skill acquisition during mealtimes; ▪ Ensuring optimal alignment and support in seating systems and/or alternate positions for individuals receiving enteral nutrition; ▪ Presentation and position/alignment strategies to support safety during oral hygiene, bathing, personal care and medication administration; ▪ Competency-based performance check-off(s) for optimal alignment and support for individuals receiving enteral nutrition; and ▪ Competency-based performance check-off for correct food texture and consistency, oral stimulation, safe mealtime presentation techniques for food, fluid and thickened liquids. The PNS competency-based training curriculum should identify the following: ▪ Required learner objectives and competencies for foundational skills in PNM;	

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		▪ For each competency, there should be a list of tasks and/or activities that must be demonstrated; ▪ A description of how staff will demonstrate mastery of the skill; ▪ The best materials, methods and staff for training; ▪ A description of how the training will reinforce "why it is important in my job to know this information;" ▪ A training schedule that is spaced out to allow participants the opportunity to practice new skills, ask questions, and obtain feedback; ▪ Include observations of staff and/or performance check-offs in work settings with outcomes documented. The Facility training curricula did not provide foundational training in the following areas: ▪ Pre-Service Training Schedule for new employees, dated 11/10, the provision of foundational skills in physical and nutritional supports identified the following topics with allotted instructional time: Physical Management (one hour), Lifting People (two hours), Adaptive Equipment (one hour), Dining Techniques (one hour), Deaf Awareness (one hour), Alternate Means of Communication (45 minutes), and Wheelchair Shop (one hour and 15 minutes). The total time to receive foundational training in physical and nutritional supports was eight hours. Instructional time for mealtimes was not sufficient to provide staff with foundational knowledge and practice of learned skills for mealtime risk indicators/triggers and problem-solving, mealtime position and alignment, diet texture and consistency, presentation techniques to enhance nutritional intake and hydration, care and use of mealtime adaptive equipment, aspiration and choking precautions, understanding a swallow study, presentation and alignment strategies to support safe swallowing during oral hygiene, bathing and medication administration, and techniques to promote optimal levels of independence and skill acquisition during mealtime. ▪ There were no specific learning objectives and competencies provided within the presented training curriculum for physical and nutritional supports to support the acquisition of PNM foundational knowledge and skills. ▪ There were assessment checklists for staff demonstration of a mechanical lift, two-person manual lift, and stand pivot transfer, but there were no performance check-offs related to mealtimes. Based on interview, Habilitation Therapies staff had been having conversations with the Staff Development Office to increase the time for Habilitation Therapies for new employee orientation. The projected date for having updated foundational and refresher classes with competency-based training was July 2011. In addition, integration of skill performance responsibilities were to be integrated into job descriptions and	

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		performance evaluations by January 2012. <u>Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable.</u> As stated above, the training curriculum submitted did not include specific learning objectives and competencies to provide foundational knowledge and skills related to the appropriate implementation of physical and nutritional supports. There was a skills-based performance check-off for physical management, but there were no skills-based performance check-offs for mealtimes. <u>All foundational trainings are updated annually</u>. No documentation was submitted to substantiate PNM foundational training was updated annually. There were no Facility staff training reports submitted to document the percentage of Facility staff, with responsibilities for the provision of direct supports, who had completed competency-based training (written test and performance check-offs) in foundational physical and nutritional management. <u>Staff are provided person-specific training on the PNMP by the appropriately trained personnel.</u> Based on a review of staff PNMP training records, documented competency-based individual-specific training was not provided by appropriately trained personnel. This was illustrated as follows: ▪ In zero of 26 records reviewed (0%) (Individual #270, Individual #316, Individual #130, Individual #375, Individual #42, Individual #141, Individual #378, Individual #131, Individual #31, Individual #158, Individual #113, Individual #246, Individual #284, Individual #160, Individual #43, Individual #348, Individual #173, Individual #320, Individual #58, Individual #297, Individual #2, Individual #139, Individual #153, Individual #207, Individual #247, and Individual #311), PNMP Coordinators had been provided instruction by licensed therapists and/or assistants. ▪ In zero of 26 records reviewed (0%), licensed therapists, assistants, and/or PNMP Coordinators had trained supervisors and/or other designated staff who would be responsible for implementation of PNMPs. ▪ In zero of 26 records reviewed (0%), licensed therapists, assistants, PNMP coordinators and/or competency-trained designated supervisors/residential managers, etc. had provided instruction to direct support professionals. <u>PNM supports for individuals who are determined to be at an increased level of risk are</u>	

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		only provided by staff who have successfully completed competency-based training specific to the individual. In zero of 26 staff training records reviewed (0%), staff who had successfully completed competency-based training provided assistance to individuals determined to be at an increased level of risk. Staff are trained prior to working with individuals and retrained as changes occur with the PNMP. Based on a review of staff training in 26 individual records, zero out of 26 (0%) showed that staff completed competency-based re-training when changes occurred on the PNMP. As stated above, staff verbalization of a change in a PNMP did not meet the standard of competency-based 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.	A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Based on review of the Facility's policies, Habilitation Therapies developed the following step-down policy related to PNM monitoring: ▪ Documenting Meal Monitoring, Policy P.4, approved 11/15/10 and implemented 12/15/10. The monitoring forms to be used were Person-Specific Dining Room Monitoring Tool and Mealtime Monitoring Drill. This policy did not address the following: ▪ Establishment of thresholds for staff re-training (foundational and/or person-specific); ▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; and ▪ Results of monitoring activities, in which deficiencies noted, being formally shared for appropriate follow-up by the relevant supervisor. The following forms were utilized to monitor PNM supports: ▪ Monthly Person-Specific PNMP Check Sheet; ▪ PNMP Monitoring and Coaching Report, dated 2/10; ▪ Person-Specific Monitoring in Dining Room; and ▪ Monthly Home Equipment Check Sheet. There was not a policy defining the monitoring processes for the completion of the Monthly Person-Specific PNMP Check Sheet, 2/10 PNMP Monitoring and Coaching Report, and/or Monthly Home Equipment Check Sheet.	Noncompliance

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		Submitted documentation regarding the validation of PNM monitoring forms listed above revealed the following compliance levels:	

Name of Monitoring Form	Date	# of Forms Requiring Follow-up versus Total # of Forms reviewed	Compliance
Monthly Person-Specific PNMP Check Sheet	7/10	11/13	15%
	8/10	13/13	0%
	9/10	11/12	8%
2/10 PNMP Monitoring and Coaching Report	7/10	7/13	46%
	8/10	7/11	36%
	9/10	7/11	36%
Person-Specific Monitoring in Dining Room	7/10	21/27	22%
	8/10	22/25	12%
	9/10	15/25	40%
Monthly Home Equipment Check Sheet	7/10	11/11	0%
	8/10	10/11	9%
	9/10	7/11	36%

The auditing of completed monitoring forms, to identify needed follow-up, was a positive move in the right direction to determine if the form[s] were completed accurately. The low level of compliance for accurately completing the form would indicate that additional training will be needed to ensure monitors understand how to complete the form. The second level of review will entail inter-rater reliability to ensure that monitors were accurately scoring the form. As stated above, the Facility monitoring policies needed to outline these steps.

<u>All members of the PNM team conduct monitoring.</u>
This is discussed with regard to Section O.2 in the examples of individuals reviewed and assessed by the Core PNMT.

<u>Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended, and assessed by the PNM team.</u>

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		A review of Facility reports, including those from Quality Enhancement, did not illustrate that a mechanism was in place to ensure timely data was provided to the PNM Team for analysis leading to the identification of potential issues, and to ensure the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual-specific and systemic levels. This information should be integrated into the Facility's Quality Assurance, Incident Management and Risk Management systems. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> Examples are provided above with regard to Section O.1 of individuals who were at risk, but had not been reviewed by the Core PNMT.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.</u> Based on the review of 13 individual records (Individual #246, Individual #284, Individual #160, Individual #43, Individual #348, Individual #173, Individual #320, Individual #58, Individual #297, Individual #2, Individual #139, Individual #153, and Individual #207), the Core PNM Team completed a comprehensive assessment for 13 of the 13 individuals reviewed (100%), but the Core PNMT did not consistently implement necessary components of the PNM process as discussed with regard to Section O.2. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> Based on the review of 13 individual records, in none of the 13 (0%) did the PNMT document the progress of individuals with PNM needs to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators.	Noncompliance
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	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.</u> Based on the review of eight individual records (Individual #240, Individual #64, Individual #210, Individual #21, Individual #209, Individual #315, Individual #245, and Individual #77) who were enterally nourished and/or received supplemental tube feedings, none (0%) of these individuals had received an annual assessment that addressed the medical necessity of the tube and potential pathways to PO (by mouth) status. Examples of individuals who received enteral nutrition and did not receive an annual	Noncompliance

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	return the individual to oral feeding.	assessment included: ▪ Individual #77's OT/PT Evaluation Update, dated 10/21/10, revealed: "she receives all nutrition and meds via G-tube while she is in the most upright position in wheelchair or bed." There was no evidence of an annual assessment to address the medical necessity of the tube. ▪ Individual #245's OT/PT Update, dated 7/28/10, stated: "[Individual #245's] oral motor skills have deteriorated over time. He is to get nothing by mouth due to increased risk of aspiration. Tasting increases the amount of saliva produced; therefore, increasing the risk of aspiration. He receives all nutrition, fluids, and meds via G-tube in the most upright position in bed or wheel chair." There was no evidence of an annual assessment to address the medical necessity of the tube. ▪ Individual #209's OT/PT Evaluation Update, dated 6/18/10, documented: "[Individual #209] does not eat orally and receives all nutrition, liquids and medications by g-tube." There was no evidence of an annual assessment to address the medical necessity of the tube. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.</u> Based on a review of an identified sample of eight individual records, individuals were provided with a PNMP that: ▪ In eight of eight records reviewed (100%), positioning instructions for wheelchair and alternate position instructions were included. ▪ In eight of eight records reviewed (100%), transfer instructions were included. ▪ In four of eight records reviewed (50%), positioning instructions after receiving enteral nutrition were included. Individual #240, Individual #64, Individual #245, and Individual #77 did not have instructions for staff to ensure these individuals remained upright for a designated period of time after receiving enteral nutrition. ▪ In three of eight records reviewed (37%), strategies for medication administration were included. Individual #240, Individual #209, Individual #315, Individual #245 and Individual #77 did not have strategies for medication administration. ▪ In eight of eight records reviewed (100%), strategies for oral hygiene were included. ▪ In eight of eight records reviewed (100%), individual adaptive equipment was included. ▪ In seven of eight records reviewed (87%), bathing/showering positioning and instructions were included. Individual #240, who was at risk for GERD, did not have instructions for elevation of her bathing/showering equipment.	

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		▪ In eight of eight records reviewed (100%), personal care instructions were included. ▪ In eight of eight records reviewed (100%), communication strategies were included. A review of individual PNMPs identified the following concerns: ▪ Individual #240 was identified at risk for GERD on 5/4/10, but her PNMP did not address her risk for GERD or present strategies to minimize the effects of GERD. For example, there were no instructions to keep the head of her bed elevated. The bathing/toileting instructions stated: "[Individual #240] uses a blue bathing trolley," but did not specify the elevation of the bathing equipment. Individual #240's PNMP stated: "provide all nutrition, liquids and medications by G-tube and use most upright position in w/c or bed when eating with G-tube," but the PNMP did not specify how long Individual #240 was to remain in an upright position after eating. The absence of these strategies had the potential to place Individual #240 at risk for aspiration. ▪ Individual #64's PNMP dated 1/1/11 did not specify how long she was to remain upright after eating, which had the potential to place her at risk for aspiration. ▪ Individual #245's wheelchair positioning picture presented him in poor alignment and support. ▪ Individual #77's Dining Plan and wheelchair positioning picture did not present her in optimal alignment and support. <u>The need for continued enteral nutrition is integrated into the PSP.</u> Based on a review of eight individual's PSPs who received enteral nutrition, none (0%) of the individual's PSPs documented the rationale for the continued need for enteral nutrition and/or attempts to return to oral or the least restrictive method of receiving enteral nutrition. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).</u> The At-Risk Individuals policy (Policy Number 006, dated 11/02/10) stated: "a regular risk assessment and management system will be used to identify persons at risk of illness and injury." A component of the At-Risk Individuals policy required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition. The assessment is designed to reduce the incidence of aspiration pneumonia and its complications and to assess continued need for enteral eating." All individuals who were enterally nourished were to be evaluated using the evaluation format. The major elements of the Aspiration	

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		Pneumonia/Enteral Nutrition Evaluation were: ▪ History to be completed by Primary Care Physician (PCP) and Registered Nurse (RN) (Diagnosis, comorbidities, history of aspiration pneumonia, other respiratory infections/conditions, hospitalizations for aspiration pneumonia/respiratory conditions, tracheostomy, reflux, emesis, and dental/oral heath issues-to be completed by dentist); ▪ Risk Level-Health Status to be completed by Team (risk level and rationale); ▪ Method of eating to be completed by PCP and Dietitian (nasogastric tube, gastrostomy tube, jejunostomy tube, type of enteral feeding and oral eating); ▪ Reason/rationale for enteral eating to be completed by PCP, RN, and Habilitation Therapies; ▪ Diagnostic tests performed to be completed by PCP, RN, and HT; ▪ Attempts to return to oral or least restrictive method of eating to be completed by HT; ▪ Current treatment; ▪ Analysis of findings to be completed by team; ▪ Recommendations; ▪ Measurable outcomes; and ▪ Action plan. The CCSSLC Aspiration Pneumonia Initiative Roll Out Action Plan stated: "Aspiration Pneumonia Initiative Database developed to allow PST to track and document the completion of Aspiration Pneumonia/Enteral Nutritional Evaluations for the individual identified as high risk for aspiration pneumonia from 1/1/11 to 3/31/11." CCSSLC identified 88 individuals who received enteral nutrition. These individuals, per the action plan, will have the following completed: ▪ Risk Assessment/Guidelines; ▪ Integrated Risk Rating Form; ▪ Aspiration Trigger Data sheet; ▪ Aspiration Pneumonia/Enteral Nutrition Evaluation; ▪ Development and implementation of a Risk Action Plan to include the development of specific programs, interventions, monitoring schedules, training, and data collection with trend analysis designed to improve outcomes; ▪ Risk Action Plan to be incorporated into Personal Support Plan (PSP); ▪ Documentation of Plan objectives in integrated progress notes; and ▪ Documentation of aspiration triggers by direct support professionals, residential supervisors, QMRPs and nurses. During the next on-site review, a record sample of individuals will be reviewed to determine the efficacy of the Aspiration Pneumonia Initiative for individuals who are	

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		enterally nourished. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. According to Habilitation Therapies, no individuals were on therapeutic/pleasure feeding programs. Hence, none (0%) of the eight individuals reviewed participated in a therapeutic feeding program.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Core and Alternate PNMT members should be held accountability to attend PNMT related continuing education courses.
2. The establishment of a dedicated PNM team has substantially increased caseloads for the remaining therapists and dietitians. The Facility should finalize its analysis and determine the number of therapy and dietitian positions required to support these professionals being active members of an individual's PST, and take necessary action to address the findings of the analysis.
3. The Core PNMT should consider the following recommendations to support successful implementation of the PNM process for those individuals at highest risk with complex health, physical, and nutritional support needs:
    a. Review completed Risk Guidelines for individuals referred to the Core PNMT to determine if appropriate risk levels have been assigned;
    b. Complete an assessment to determine the status of safe positioning for an individual within natural environments (nighttime positioning, seating system, bathing, tooth brushing, classroom, work, leisure, medication administration, etc.) to determine the efficacy of current PNMP strategies, including staff instructions, prior to the Core PNMT and PST meeting;
    c. Identify individual triggers for identified risk indicators, such as aspiration pneumonia, and integrate these triggers into relevant working plans, such as the PNMP, Dining Plan, BSP, Nursing Care Plan, etc.;
    d. Ensure the assessment provides clinically justified techniques for mealtime (including individuals who were enterally nourished), oral care, bathing, dental appointments, bedtime positioning, medication administration, etc.;
    e. Develop an individual-specific action plan format to track completion of recommendations. This should be incorporated into the PSP;
    f. Include, in the analysis section of the PNM Evaluation, assessment data that provides justification and rationale for the recommendations. The analysis should provide a correlation between the identified high-risk indicators that resulted in referral to the Core PNMT and the recommendations;
    g. Include, in the recommendations and measurable outcomes, criteria to measure the efficacy of the interventions;
    h. Develop implementation strategies to ensure recommendations and measureable outcomes are implemented;
    i. Ensure staff complete performance check-offs to document staff competency for identified skills for those individuals at highest risk;
    j. Develop simple methods to document, monitor, and track clinical objective data to support the effective implementation of recommendations;
    k. Implement a mechanism to report a change in an individual's status to the Core PNMT, to enable the Core PNMT to evaluate the plan and/or make modifications to the plan; and
    l. Develop a person-specific monitoring plan, for the Core PNM Team to complete, which is correlated to PNM recommendations and measurable outcomes, enabling the Team to quickly determine the efficacy of identified implementation strategies.
4. Individuals with identified physical and nutritional support needs should have a timely, proactive, comprehensive assessment completed; an appropriate PNMP developed and implemented; regular review, documentation, monitoring and analysis to determine the efficacy of the

supports provided; and modifications to plans, as necessary.

5. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided at both the individual-specific and systemic level. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems.
6. The PNS competency-based training curriculum should identify the following:
    a. Required learner objectives and competencies for foundational skills in PNM;
    b. For each competency, there should be a list of tasks and/or activities that must be demonstrated;
    c. A description of how staff will demonstrate mastery of the skill;
    d. The best materials, methods and staff for training;
    e. A description of how the training will reinforce "why it is important in my job to know this information;"
    f. A training schedule that is spaced out to allow participants the opportunity to practice new skills, ask questions, and obtain a lot of feedback; and
    g. Include observations of staff and/or performance check-offs in work settings with outcomes documented.
7. The monitoring policy for mealtime and PNMP monitoring should describe a monitoring system that includes identified performance indicators to ensure continued staff competency with regard to knowledge and skills acquired in competency-based physical and nutritional support foundational training, criteria for and identification of who will complete the monitoring, competency-based training for monitors, description of each indicator with monitoring strategy, definition of staff re-training thresholds, a validation/inter-rater reliability process, the use of monitoring reports to assist in the identification of problematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoring system into Facility Risk Management and Quality Improvement systems. Such policies need to define "regular" monitoring as required by the Settlement Agreement. In addition, policies for monitoring staff's implementation of PNMPs should be reviewed and revised, and Facility procedures should be developed to ensure adequate monitoring as required by the SA and HCG (Health Care Guidelines).
8. Evaluation should be conducted of individuals who are enterally nourished to determine the appropriateness of receiving enteral nutrition, and, if not, to identify strategies to transition a person to oral intake, if appropriate.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section P; o The following documents: Occupational Therapy (OT) and Physical Therapy (PT) Assessments, OT/PT/SLP consultations for the last year, OT/PT Treatment Plans, OT/PT Skill Acquisition Programs, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan (PNMP) with pictures, PNMP person-specific monitoring, PNMP Clinic Notes, competency-based training for staff, wheelchair assessment, OT/PT PSP monthly progress note and dining plan for the following 15 individuals: Individual #84, Individual #51, Individual #375, Individual #133, Individual #221, Individual #335, Individual #114, Individual #338, Individual #150, Individual #145, Individual #89, Individual #110, Individual #131, Individual #43, and Individual #124; o Policies and Procedures related to OT/PT Supports and Services, 10/09 through 12/10; o List of Individuals who use wheelchairs as primary mobility, those with Transport Wheelchairs, those with other Ambulation Assistive Devices, and those with Orthotics and/or Braces, dated 11/17/10; o List of Individuals who have had a Decubitus/Pressure Ulcer during the past year, undated; o List of Individuals who have experienced a Falling Incident during the past three months; dated 11/19/10; o PNM Maintenance Log utilized to track Modifications made to adaptive/assistive equipment, dated 11/17/10; o OT/PT Evaluation Template, undated; o Five most current OT/PT assessments and corresponding PSPs, 11/09 through 11/10; o Wheelchair Evaluation and Work Order Template, undated; o Five most current Wheelchair Evaluations/Assessments and related documentation, 10/08 through 12/10; o OT/PT Related Spreadsheets, undated; o OT/PT Monitoring Forms, for 10/10; o OT/PT Summary Reports, Quality Assurance Reports, and Corrective Action Plans generated between 5/10 and 10/10; and o List of Individuals receiving direct OT and/or PT services and focus of intervention, undated. ▪ **Interviews with**: o Dr. Angela Roberts, AU.D., CCC-A, F-AAA, and Habilitation Therapies Director; o Paul Osborne, PT; o Maria Garcia, PT; o Nancy Droke, OT; o Tami Loudermilk-Flores, OT; and

	○ Dana VerHey, Quality Enhancement Program Auditor ▪ **Observations of**: ○ Apartment 515; and ○ Apartment 516.
	Facility Self-Assessment: The Plan of Improvement for Section P indicated the Facility was in noncompliance with all indicators in Section P. The POI provided chronological updates in the Comments/Status column of what has been accomplished to date. An additional POI form provided an action plan, including the following fields for Section P.1 and Section P.2: ▪ Compliance Visit/Section and Recommendation; ▪ Outcome; ▪ Action Step; ▪ Evidence; ▪ Responsible person; ▪ Start date; ▪ Target date; and ▪ Completion Status. The Monitoring Team's findings were consistent with the Facility's findings of noncompliance for all indicators in Section P. POI Monitoring Forms were submitted for Section P from May 2010 to September 2010. Occupational Therapist(s), Physical Therapist(s), Physical Therapy Assistant(s), Certified Occupational Therapy Assistant(s), and a Program Compliance Monitor completed a monitoring tool for the same individual. The PCM then compared the Therapist's answer to the PCM's answer for each question of the monitoring tool. If the therapist and the PCM's answers were the same, a score of 100% was documented showing 100% agreement. If the therapist and the PCM's answers were not the same a score of 0% was documented. Inter-rater reliability scores were not calculated for the POI Monitoring forms submitted for May through September 2010. The POI Monitoring Tools, for Section P for October 2010, documented a percentage indicating inter-rater reliability between the therapist and the PCM. An overall inter-rater reliability for the entire tool was also provided, along with an explanation of how many tools were completed. In addition, the issue of whether the therapist and PCM agreed that the Facility was in compliance with each question was indicated in the second column. An "S" for substantial compliance indicated this. The issue of disagreement between the therapist and PCM for the Facility's compliance was indicated in the third column. An "S" indicated the therapist did not score the Facility in compliance, however the PCM did. Thirteen out of 26 answers showed agreement between the SLP and the PCM. An inter-rater reliability score of 50% was achieved for the October POI Monitoring for Section P. The Plan of Correction stated: "instructions for monitoring tools have been completed. Therapists were to be in-serviced on instructions for monitoring tools on 11/17/10. Mitigation meetings were to be held in the beginning of December."

	The achievement of a defined inter-rater reliability threshold between the respective therapists and the PCM will be critical to ensure confidence with indicators that are scored compliant. The revision of indicator instructions and the provision of therapist re-training presented a sound approach to achieve inter-rater reliability. The Facility should continue to expand its self-assessment activities, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate the monitoring tools, particularly to separate out the different types of reviews to be completed using different methodologies and samples; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring on the review tools and their implementation; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. During the entrance conference, the CCSSLC Habilitation Therapies Director indicated that the Habilitation Therapy Department had implemented the following activities related to Section P following the last compliance review: ▪ "Section p.4 of the POI suggested the Facility should develop and implement a system to monitor and address identified occupational and physical therapy needs; the condition, availability and effectiveness of physical supports and adaptive equipment; as well as the implementation by direct care staff of thee interventions. Two separate policies were developed to address these specific concerns. Policy P.2 (Training Staff on Physical Nutritional Management Plans) was recently implemented across campus. Staff is provided person-specific training on the PNMP by appropriately trained personnel. PNM supports for individuals are only provided by staff that have successfully completed competency-based training specific to the individual. Staff are trained prior to working with individuals and retrained as changes occur. Staff completed not only general training, but person-specific training related to the implementation of OT/PT recommendations. Policy P.3 (Maintaining Adaptive-Assistive Equipment) was also recently implemented across campus. This policy dictates how staff ensures that all equipment is available and in good condition. This policy also includes a system for multiple levels of monitoring."
	Summary of Monitor's Assessment: Facility Administration, in collaboration with the Habilitation Therapy Director, had increased the number of physical therapy positions and had approved the recruitment of two additional occupational therapists. However, at the time of the review, the current therapy caseloads for occupational therapists and Physical Therapists continued to present challenges for achieving compliance with Section P of the Settlement Agreement. The Habilitation Therapies Director and staff had begun the process of analyzing the current staffing needs of occupational and Physical Therapists, and the Facility is encouraged to address the findings of the analysis once completed. The OT/PT Evaluation template had been updated, but none of the individual records the Monitoring Team reviewed incorporated the revised OT/PT Evaluation template components. Record reviews also showed that individuals had not received an interim update when there were changes in status, such as, but not

	limited to, a diagnosis of aspiration pneumonia, a fracture, falls, diet downgrade, unplanned weight loss, skin breakdown, and/or community transition. Moreover, plans had not been developed that addressed the therapy supports that the therapists, PNMP Coordinators, and/or direct support professionals were providing to individuals. Many issues were noted related to the timely provision of wheelchairs and/or wheelchair parts. This had the potential to impact individuals who were at risk, such as individuals at risk due to aspiration pneumonia, and/or skin breakdown. Although orders had been placed, they had not been filled. As the Monitoring Team recommended while on-site, it is essential that this issue be resolved as quickly as possible.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u> Facility Administration, in collaboration with the Habilitation Therapy Director, had increased the number of Physical Therapy positions and had approved the recruitment of two additional Occupational Therapists. However, at the time of the review, the current therapy caseloads for Occupational Therapists and three Physical Therapists continued to present challenges for compliance with Section P of the Settlement Agreement. There were 283 individuals living at CCSSLC according to the current census provided to the Monitoring Team. The following chart represented therapy and therapy assistant caseloads at the time of the review:	Noncompliance

Occupational Therapist(s) and Certified Occupational Therapy Aide(s)	**Current Caseloads and Responsibility**
OT #1	Supported 146 individuals and Core PNMT member
OT #2	Supported 76 individuals and Alternate PNMT member
OT #3 (Contracts for eight to 10 hours per week)	Supported 60 individuals
OT #4	Currently recruiting
OT #5	Currently recruiting
COTA #1	Supported 60 individuals
COTA #2	Supported 64 individuals
Physical Therapist(s) and Physical Therapy Aide(s)	**Current Caseload**
PT #1	Chairperson of the PNMT

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PT #2	Supported 82 individuals
PT #3	Supported 37 individuals and Alternate PNMT member
PT #4	Supported 39 individuals
PT #5 (Contracts for 8.5 hours per week)	Supported 60 individuals
PT #6 (Contracts for eight to 10 hours per week)	Supported 64 individuals
PTA #1	Supported 60 individuals
PTA #2	Supported 64 individuals

There were three filled positions for occupational therapy, and two additional positions had been approved. Per report, the Habilitation Therapies Director contracted with an Occupational Therapist for eight to 10 hours per week, and was recruiting two additional Occupational Therapists. Reportedly, recruitment efforts included placement of advertisements in the local newspaper; posting of an advertisement online with the American Occupational Therapy Association; attendance at job fairs; and postings at several colleges that certify therapists to work in the field.

The current caseloads for the two full-time Occupational Therapists and the contract Occupational Therapist were too large to enable these therapists to be active members of the individuals' PSTs, and were presenting significant challenges in meeting the standards set forth in Section P of the Settlement Agreement. Efforts to continue to recruit two additional Occupational Therapists should continue.

There were four full-time Physical Therapists, and two contract Physical Therapists at the time of the review. Significant progress had been made in lowering the caseloads of the Physical Therapists, with the exception of one Physical Therapist who had a high caseload of 82 individuals in addition to supervising staff in the Wheelchair Department. Furthermore, one contract Physical Therapist worked 8.5 hours per week and had a caseload of 60 individuals. The second Physical Therapist worked eight to 10 hours per week and had a caseload of 64 individuals. These three Physical Therapists, with their current caseloads, will be significantly challenged to meet the SA requirements of Section P and participate as active members of an individual's PST.

Thirteen PNMP Coordinator positions were approved, and there were no vacant positions.

The document entitled Staff to Individual Ratio, dated 11/30/10, indicated the ratio for OT was 1:127.47 and PT was 1:63. The psychology staff-to-individual ratio required by

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		the Settlement Agreement was 1:30. OTs and PTs had similar duties with regard to assessment, planning, monitoring, and provision of direct supports and/or oversight. As a result, therapists were not active members of the PSTs, as evidenced by, but not limited to, their absence in annual PSP meetings, insufficient time to provide direct therapy (only one individual at CCSSLC) was provided with direct therapy, completion of comprehensive OT/PT Evaluations per established guidelines, development and integration of therapy recommendations into formal skill acquisition programs, development of instructional programs for PNMP Coordinators and/or staff, and the development of informal strategies to reinforce assessment recommendations. The Habilitation Therapies Director and staff had begun the process of analyzing the current staffing needs of Occupational and Physical Therapists through the identification of required work tasks and the corresponding time needed to complete these tasks. This should lead to the development of realistic recommendations regarding caseload for therapists. Based on interview, it was anticipated the analysis would be completed by July 2011. Based on a review of CVs for each therapy clinician, the appropriate qualifications were found for the Habilitation Therapy Director, two OTs, one contract OT, four PTs, and two contract PTs. All OTs, COTAs, PTs, and PTAs licenses were current. Continuing education documentation for the OTs, COTAs, PTs, and PTAs documented attendance at the following continuing education courses and/or conferences:	

Continuing Education	OT/COTA	PT/PTA
Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management (6/16/10)	3 OTs, 1 COTA	
Issues in Nutritional Management (7/7/10)	1 OT, 1 COTA	1 PTA
PNMP and Wheelchair Clinic Webinar (7/7/10)	1 OT	I PT, I PTA
PNMP and Wheelchair Clinic Webinar (7/19/10)	I OT	2 PTs, I PTA
PNMT Identification of Risk and Development of Interventions (7/30/10)	2 OTs, 1 COTA	2 PTs
PNMT and Wound Care Investigation (8/13/10)	2 OTs, 1 COTA	1 PT
Seating and Positioning for Dysphagia (9/1/10)	2 OTs	4 PTs, I PTA

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Competency-Based Training (10/27/10)		4 PTs, 2 PTAs
20th Annual Habilitation Therapies Conference (9/20/10 through 9/21/10)	3 OTs, 2 COTAs	3 PTs, 1 PTA
Texas Autism Conference (10/6/10 through 10/9/10)	1 OT, 2 COTAs	
Introduction to Pediatric Medical Screening (11/1/10)		1 PT
PTA Based Treatment Options for the Balance/Vestibular Patient (11/2/10)		1 PT
Sports Nutrition for Therapists (11/2/10)		1 PT
Introduction to the Vison System (11/2/10)		1 PT
Rotator Cuff Injury: Diagnosis, Treatment and Rehabilitation (11/19/10)		1 PTA
Shoulder Impingement: Diagnosis and Treatment (11/17/10)		1 PTA

Two occupational therapists were registered for the Beckman Oral Motor Assessment and Intervention Protocol workshop on January 13 to 14, 2011 in Corpus Christi.

The Facility should continue to support therapist's attendance at a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at CCSSLC.

Fifteen records were reviewed, including those for: Individual #84, Individual #51, Individual #375, Individual #133, Individual #221, Individual #335, Individual #114, Individual #338, Individual #150, Individual #145, Individual #89, Individual #110, Individual #131, Individual #43, and Individual #124. These 15 individuals had identified needs related to, but not limited to, movement, mobility, range of motion, independence, regression of functional skills, a change in status, and/or community transition.

<u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u>
There were no new admissions to CCSSLC since the baseline review.

<u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u>
The OT/PT Evaluation template had been updated and provided the following instructions:

- "The Evaluation instructions and template provide guidelines for assessment.

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		All sections will not be applicable to all individuals. ▪ Always provide rationale for recommendations as well as functional, measurable objectives as applicable. ▪ Ensure that recommendations are clearly stated and include responsible persons for implementation and criteria to assess efficacy of the program. ▪ Ensure that recommendations for supports or activities other than direct therapy requiring a licensed professional are incorporated into the PSP so they may be integrated into the individual's daily routine." The OT/PT Evaluation template included the following sections: ▪ General Information; ▪ Behavioral Consideration; ▪ Motor/Functional Evaluation/PNMP: o Physical Management Information; o Reflexive/Orthopedic Abnormalities; o Range of Motion; o Muscle Tone/Strength; o Handling/Transferring; o Mobility/Locomotion; o Respiratory Function; o Sensorimotor Function; o Fine Motor Function; and o Activities of Daily Living; ▪ Oral Motor/Eating Ability/Nutritional Status: o Nutritional Status; o Oral/Developmental Abnormalities; o Oral Control; o Diet Texture/Method of Feeding; o Behavioral Considerations; and o Feeding Techniques; ▪ Assistive/Supportive Devices; ▪ Summary/Recommendations; ▪ Measurable Objectives; ▪ Responsible Persons; ▪ Monitoring Schedule/Staff; and ▪ Reassessment Schedule. None of the 15 individual records reviewed (0%) had an OT/PT Evaluation and/or Update that incorporated the revised OT/PT Evaluation template components. Recommendations included in the assessments reviewed did not reflect	

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		individualization, nor did they identify functional, measurable outcomes. The standard generic recommendation(s) for individuals in OT/PT Evaluations were: ▪ Continue PNMP. ▪ Continue current assistive equipment as described in PNMP. ▪ Continue PT/OT Level 3 tracking with evaluation update annually, evaluation every three years and answer consults upon request. ▪ Review case by Nutritional Management Team (NMT) every 30 days to address any concerns. ▪ Continue dining plan instructions and mealtime adaptive equipment. All OT/PT Evaluations were signed and dated by Occupational and Physical Therapists. <u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three years, with annual interim updates or as indicated by a change in status.</u> Based on individual record reviews, none of the seven individuals who had experienced a changes in status (Individual #84, Individual #51, Individual #375, Individual #221, Individual #335, Individual #114, and Individual #15 (0%) had received an interim update. Changes in status included events such as, but not limited to, a diagnosis of aspiration pneumonia, a fracture, falls, diet downgrade, unplanned weight loss, skin breakdown, and/or community transition. The following individual concerns were identified: ▪ Individual #84 transitioned to the community on 9/2/10. He received an Occupational/Physical Therapy Screening on 9/26/09. The screening addressed previous recommendations, results of recommendations, status changes since last evaluation, current equipment, current diet level, nutritional management committee activity, current self help skills and recommendations. He received an Occupational/Physical Therapy Discharge Summary, dated 8/24/10, but he did not receive an updated OT/PT Evaluation prior to his community transition to provide current information to his community providers. ▪ Individual #51 was referred for community placement on 11/15/10. Her OT/PT Evaluation Update, dated 9/30/10, did not address the supports needed for successful community transition. ▪ Individual #375 was hospitalized on 4/17/10, and discharged on 4/17/10 with a diagnosis of fracture of the right femur and received an open reduction internal fixation (ORIF) intramedullary rod implant. Individual #375 was identified at high risk for skin breakdown/decubitus ulcer on 2/22/10, and was identified as having a skin breakdown. Her most current OT/PT Evaluation Update was dated 1/13/10. There was no OT/PT Update and/or OT/PT consultations post fracture to address her status and potential changes needed	

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		to minimize her risk of fractures. The OT/PT Evaluation Update stated: "There have been no reported wounds requiring OT/PT intervention." ▪ Individual #221 was identified at high risk for chronic respiratory infections/pneumonia on 7/27/10. Individual #221's OT/PT Evaluation Update, dated 4/10/10, documented: "[Individual #221] was sent on an MBSS this past year. Moderate silent aspiration with thin, nectar and honey consistencies. Recommendations were to downgrade him to puree texture diet and pudding fluids with aspiration precautions." His OT/PT Evaluation Update did not assess his nutritional status, oral/developmental abnormalities, oral control, behavioral considerations, and/or mealtime techniques. ▪ Individual #335's diet was downgraded during the past 12 months. His OT/PT Evaluation Update, dated 10/27/10, acknowledged his diet texture was pureed texture with pureed bread and honey/applesauce thick fluids, because he was at risk for choking on other diet textures and thin fluids. His OT/PT Evaluation Update did not discuss the reason for the diet downgrades, and did not assess his nutritional status, oral/developmental abnormalities, oral control, behavioral considerations, and mealtime techniques. ▪ The document entitled "Individuals who have had a fall" between 11/1/09 to 11/16/10 identified Individual #114. The document did not identify the number of fall(s) he experienced. His OT/PT Evaluation Update, dated 4/15/10, documented no falls were reported. There were no OT/PT Updates and/or consultations to address his fall(s). ▪ Individual #150 received an MBSS on 10/27/10. The recommendations were to "continue ground texture diet, thin liquids and may offer the patient pureed texture if the patient continues to refuse ground texture." Her most current OT/PT Evaluation Update was dated 8/26/10. There was no OT Update and/or consultation to address the need for her MBSS and to assess her current nutritional status. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u> Zero of the 15 (0%) assessments reviewed addressed medical issues and health risk indicators, which would have an impact on the analysis utilized to establish rationale for recommendations/therapeutic interventions. <u>Evidence of communication and or collaboration is present in the OT/PT assessments.</u> Based on record review, 15 of the 15 OT/PT Evaluation and/or Updates (100%) included signatures and date by the OT and PT.	
P2	Within 30 days of the integrated	<u>Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has</u>	Noncompliance

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	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.	been developed as part of the PSP. The number of individuals receiving direct and/or indirect OT and/or PT services from a therapist was one individual (0.35% of current census), PNMP Coordinators provided supports to 68 individuals (24% of current census), and direct support professionals provided supports to 111 individuals (39% of current census). Numbers of individuals receiving services from a therapist, PNMP Coordinators, and/or direct support professionals per living unit are listed below:	

Therapist	PNMP Coordinator	Staff
Atlantic Unit		
One individual	10 individuals	Six individuals
Tropical Unit		
	Four individuals	No individuals
Pacific Unit		
	29 individuals	45 individuals
Coral Sea		
	25 individuals	60 individuals

Based on a review of eight individuals (Individual #133, Individual #338, Individual #145, Individual #89, Individual #110, Individual #131, Individual #43, and Individual #124) who were selected from the submitted list of individuals receiving direct/indirect OT/PT services from the therapist, PNMP Coordinators and/or direct support professionals and focus of intervention, none of the eight (0%) had a plan developed within 30 days of the date of the assessment/update. The following individual examples document the absence of a plan:

- Individual #133's OT/PT Evaluation, dated 6/29/10, recommended: "continue with multi-layered wrappings on both lower legs, for lymphedema therapy." Individual #133 received direct treatment by a therapist for "lymphedema to manage swelling of lower extremities." There was no therapy treatment program submitted or monthly progress updates.
- Individual #145 received oral stimulation for facial muscle strengthening and stimulation by a PNMP Coordinator. Her PNMP, dated, 10/4/10, stated "provide external oral motor stimulation X 5 each side of mouth by wrapping damp washcloth on 2 fingers to be done by PNMP coordinators 4 times per week. (Data sheet to track)." Her OT/PT Evaluation, dated 7/15/10, did not discuss the provision of oral stimulation for facial muscle strengthening and stimulation, and/or make a recommendation for oral stimulation. There was no instructional program submitted to guide the PNMP Coordinator in the provision of these supports.
- A PNMP Coordinator provided Individual #89 gentle movement and oral

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		stimulation for facial muscle strengthening and stimulation. Her PNMP, dated, 10/4/10, stated: "provide external oral motor stimulation X 5 each side of mouth by wrapping damp washcloth on 2 fingers to be done by PNMP coordinators 4 times per week. (Data sheet to track). Provide gentle movement exercised to both hands/upper extremities 3-5x/wk (data sheet to track)." The Physical Nutritional Management Data sheet did not document these interventions. The OT/PT Evaluation Update, dated 9/8/10, did not make a recommendation for gentle movement and/or oral stimulation, nor did the assessment address the rationale for these interventions. There were no measurable, functional outcomes to determine the efficacy of these interventions. Her Daily Schedule did not document the provision of these interventions. ▪ Individual #110 received oral stimulation for facial muscle strengthening and stimulation. The OT/PT Evaluation, dated 12/6/10, did not address and/or recommend these interventions. ▪ Individual #131's staff provided "ambulation-maintain independence." Individual OT/PT Evaluation, dated 8/12/10, stated "[Individual #131] walks with one staff assistance holding the gait belt and no assistive device. He has a scissoring gait, trunk slightly flexed forward and laterally flexed to the left side. He walks from the unit to the outside and back to the hallway." A PSPA, dated 6/2/10, documented his three recent incidents of falling. On 6/1/10, the PST recommended a "consult to evaluate his stability" with a projected completion date of 6/8/10. Habilitation Therapies Consult Database documented a request for "a gait assessment for unassisted walking" received on 7/29/10 and answered on 7/30/10. The consultation was not submitted. His PNMP, dated 12/16/10, documented "[Individual #131] ambulates with hard shell helmet, gait belt with PNMP Coordinator in the hall way or outdoors weather permitting for 10-15 minutes as tolerated, 4-5 X/Wk." There was no instructional program submitted for this intervention. ▪ A PNMP Coordinator provided Individual #43 with "gentle movement to maintain movement." The PNMP, dated 9/27/10, documented "gentle movement exercises: neck rotation to the right, shoulder flexion and abduction, elbow extension, wrist and finger extension performed by PNMP Coordinators. Report any redness or skin irritation to the nurse." The OT/PT Evaluation Update, dated 1/18/10, stated: "PNMP Coordinators will provide gentle movement exercised to her neck and both upper extremities." There was no recommendation to address the gentle movement exercises. There was a recommendation to "continue providing external oral stimulation to reduce risk of aspiration," but this recommendation was not being implemented. ▪ Individual #124's staff provided gentle movement, positioning and oral stimulation to maintain movement, enhance circulation and skin integrity. The	

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		OT/PT Evaluation, dated 3/16/10, recommended: "continue with external oral stimulation to stimulate facial muscles due to not eating PO [by mouth] and opportunities for active range of motion of upper and lower extremities during recreational activities and daily living tasks." These recommendations did not identify the responsible person(s) for implementation, and/or criteria to assess the efficacy these interventions. There was no rationale for these recommendations within the body of the evaluation. These recommendations were not integrated into the PSP and/or the individual's daily schedule/routine. <u>Within 30 days of development of the plan, it is implemented.</u> As stated above, there were no plans developed and/or implemented. <u>Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.</u> None of the 8 individuals (0%) with direct and/or indirect OT/PT services had the plans integrated into the PSP. <u>The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.</u> As noted above, there were no plans for the sample of individuals reviewed. <u>On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results.</u> When individuals' status changed, there was not consistent review and/or modifications to plans. This is discussed above, and examples provided with regard to Section P.1 of the Settlement Agreement.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Staff implements recommendations identified by OT/PT.</u> Examples are provided above with regard to Section O.4 of the Settlement Agreement, referencing staff not following PNMPs, which OTs and PTs had recommended. As stated in the Monitoring Team's last report, PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training with specific learning objectives and identified competencies. Such training should include foundational knowledge and skills related to the appropriate implementation of physical assistance supports including, but not limited to: risk indicators and problem-solving; position, alignment, and support; proper body mechanics for lifting; provision of adequate support during transfers; physical	Noncompliance

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		assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming, and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include skills-based performance check-offs. Therapists should conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required. It is essential that PNMP Coordinators are competent in the performance of their duties, because these staff are responsible for service delivery, as well as monitoring of direct support professionals. Based on documentation provided, "competency-based testing was currently being revised to include these specific areas. Due to the urgency of other portions of the POI, this section will be addressed over the next 6 months with full implementation by January 2012." <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.</u> Based on review of individual records, direct support professionals were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for none of eight individuals reviewed (0%) in the sample. Discussion with regard to Section O.5 provides further information related to competency-based training.	
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	<u>System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology.</u> Maintaining Adaptive-Assistive Equipment, Policy P.3, was approved on 11/15/10 and implemented on 12/15/10. Reportedly, staff ensured that all equipment was available and maintained in good condition. The policy included a system for multiple levels of monitoring. The Habilitation Therapies Department was currently working on adding "effectiveness" of supports and treatments to the monitoring process. Policy P.3 documented the following steps: ▪ The HT staff ensured that the PNMP was approved during admission, 30 day-post admission, annually and at any addendum PSP, and that it listed all required adaptive assistive equipment. ▪ The staff that had direct contact responsibilities for implementing the PNMP would review the front of the PNMP daily and provide listed adaptive/assistive equipment as prescribed. Staff entered this information onto the individual's integrated progress notes. ▪ If the required equipment was missing and/or broken, staff would request a	Noncompliance

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	of these interventions.	replacement from the residential team leader or designee. The team leader entered the request information onto the home log. ▪ The day Residential Coordinators and PNMP Coordinators randomly checked the PNMP of individuals assigned to his/her residence throughout the day to ensure that the prescribed adaptive and assistive equipment was available, in good condition, and used as prescribed. Missing and/or broken equipment was to be entered onto the residence log, as well as the date and who was notified. ▪ The PNMP Coordinator used the "Monthly Person-Specific PNMP Check Sheet" to monitor the use of prescribed adaptive equipment and assistive devices on a monthly basis, and provided feedback to residential team leaders or designees. They would also notify the prescribing therapist as needed. ▪ The Unit Director or designee would maintain a supply of prescribed adaptive equipment and assistive devices for replacement as needed. ▪ The therapists would monitor the adaptive-assistive equipment and its condition annually at the PNMP clinic prior to the Personal Support Plan Meeting. None of the 14 individual records reviewed (Individual #51, Individual #375, Individual #133, Individual #221, Individual #335, Individual #114, Individual #338, Individual #150, Individual #145, Individual #89, Individual #110, Individual #131, Individual #43, and Individual #124) (0%) had an annual comprehensive evaluation/review of all prescribed PNMP adaptive/assistive equipment during the PNMP Clinic. Individual #84 had transitioned to the community and as a result had not been assessed in the PNMP Clinic. The following issues were noted: ▪ None of the PNMP Clinic notes documented therapists and/or other staff in attendance, with the exception of a Physical Therapist signature for Individual #110. ▪ Individual #375 had been identified as having skin breakdown and was identified as at high-risk for skin breakdown on 2/22/10. The PNMP Clinic Minutes, dated 1/13/10, documented "fabrication of new seating system to begin within 6 months." It was unclear why the priority assigned to Individual #375 was low. ▪ Individual #221's PNMP Clinic Minutes, dated 1/14/10, confirmed "foam-in-place seat. Pressure map 2° ↑ areas of ↑ pressure seat to be placed on solid seat remove sling and add solid base. (Consult to follow)." A Wheelchair Evaluation and Work Order, with an assessment date of 4/10/10, did not address his wheelchair priority, and it was unclear if a new seating system was recommended and/or ordered. The document entitled, Wheelchair Consults by Priority, dated 1/6/11, identified Individual #221's consult priority as high with the following items needed: "seat, wheelchair, seat." The days in process for this consult were 357 days with no explanation and/or justification for the	

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		excessive amount of time to receive a seating system. There was no discussion of the availability, function, condition, and/or effectiveness of his hospital bed, floor mat beside bed, and padding on wall beside bed. ▪ Individual #335's PNMP Clinic Minutes, dated 9/2/10, acknowledged: "nursing to check his foot due to 2nd digit to right foot bruised. Observe at meals for need of an inner lip plate due to a purred (done) he is 0 spillage with regular plate." There was no discussion of the fit, availability, function, condition, and/or effectiveness of his rolling walker with seat for safe ambulation and/or gait belt for safe transfers and ambulation. ▪ Individual #114 did not have PNMP Clinic Minutes because "Tropical [residential unit] does not have a clinic (N/A)." Individuals #114's PNMP, dated 5/20/10, identified the following assistive equipment: "work lumbar support belt to be worn as desired for work activities, he may choose not to wear it and foam wedge pillow for head/trunk elevation in bed." Individual #114 did not have his assistive equipment reviewed on an annual basis as evidenced by the absence of a PNMP Clinic for the Tropical residence. ▪ Individual #150's PNMP Clinic Minutes, dated 7/27/10, documented: "1) pressure mapping [with] no areas of pressure noted; 2) foot assessment- [callouses] noted ball R foot/L heel. Good color noted [with] [both] feet, and 3) trim top back of w/c-consult to W/C department." A Wheelchair Evaluation and Work Order with an assessment date of 7/27/10 did not address the completion of the recommendation to trim the back of her wheelchair. There was no discussion of the availability, function, condition, and/or effectiveness of her hospital bed and floor mat, which was documented as assistive equipment on her PNMP dated 10/25/10. ▪ Individual #89's PNMP Clinic Minutes, dated 8/31/10, stated: "reassess [both] wrist/hands (splint?)." There was no OT/PT Evaluation Update and/or consultation to reassess her wrist and hands. ▪ Individual #145's PNMP Clinic Minutes, dated 6/17/10, did not address the availability, function, condition, and/or effectiveness of her communication board, electric hi-low hospital bed with padded bed frame under edge of mattress, pressure relief mattress and floor mat by bed for safety. ▪ Individual #110 PNMP Clinic Minutes, dated 11/18/10, acknowledged: "L heel area skin integrity (Stage 1 breakdown) nursing notified. Nursing discussed re: use of heel protectors while in bed. Noted in IP notes' pressure mapping revealed area of significant pressure [both] on both ischial tuberosity [known as sitz bones]. Consult with w/c [department] to move headrest to tilt up and move back 1. A note was written on her POR [PT signature]." Wheelchair Evaluation and Work Order and Mat Assessment for Seating and Positioning, both with assessment dates of 11/18/10, did not address the significant pressure areas as noted above. The Wheelchair Evaluation and Work Order	

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		identified the condition of her seating system as "good." Wheelchair Consults by Priority identified Individuals #110 as high priority for a wheelchair with days in process documented as 49 days. The reason was unclear for the incongruency between these multiple documents related to the status of her seating system. ▪ Individual #131's PNMP Clinic Minutes, dated 7/27/10, did not assess the fit, availability, function, condition, and/or effectiveness of his hospital bed, floor mat by bed for safety, and gait belt and helmet for ambulation and safety. ▪ Individual #43 did not have PNMP Clinic Notes because "she was in the hospital," but there was no documentation to reschedule an assessment of her assistive equipment in PNMP Clinic. ▪ Individual #124's PNMP Clinic Minutes, dated 3/16/10, documented "pressure map OK as per [PT] and continue hand splints." The PNMP Clinic did not assess the fit, availability, function, and condition of her right, soft hand splint to enhance proper positioning, hospital bed, bed rails and pads for safety, pressure relief mattress to enhance skin integrity and soft shoes due to foot deformities. Individual #124 was identified as having a pneumonia incident, which further emphasized the importance of assessing her assistive equipment to minimize her risk of pneumonia. ▪ Individual #133's PNMP Clinic Minutes, dated 6/29/10, documented the recommendations in her OT/PT Evaluation but did not assess the fit, availability, function, condition, and effectiveness of her prescribed PNMP assistive equipment. ▪ Individual #338's PMMP Clinic Minutes, dated 11/16/10, documented "continue the use of high top shoes," but high top shoes were not listed as needed assistive equipment on her PNMP. There was no discussion related to the continued use of her elbow pads as documented on her PNMP. ▪ Multiple PNMP Clinic minutes documented a foot assessment, but the prescribed footwear, for example, the continued use of high top shoes for Individual #338, was not included under assistive equipment in the PNMP. ▪ The Monitoring Team observed multiple individuals who were not wearing shoes. Individuals (children, adolescents, and adults) wear shoes on a daily basis in a variety of environments whether they are ambulatory and/or non-ambulatory. Shoes provide necessary support to individuals and prevent injuries. Shoes should be worn unless they are medically contraindicated. Based on discussions with therapists, there were ongoing issues with regard to programmatic staff not following instructions that individuals wear shoes. Consideration should be given to incorporating the wearing of shoes and/or identification of prescriptive shoes in the PNMP to support the importance of individuals wearing shoes on a daily basis.	

#	Provision	Assessment of Status	Compliance
		Maintaining Adaptive-Assistive Equipment, Policy P.3 stated: "the therapists will monitor the adaptive-assistive equipment and condition annually at the PNMP Clinic prior to the Personal Support Plan Meeting." Guidelines for the PNMP Clinic should be developed, including but not limited to the following: ▪ Therapists' PNMP Clinic attendance should be documented through signatures on sign-in sheets; ▪ All PNMP prescribed assistive equipment should be assessed on an annual basis for fit, availability, function, condition and effectiveness; ▪ A documentation process should be established for resolution of problems with fit, availability, function, and condition of prescribed equipment; ▪ PNMPs should incorporate prescribed footwear as discussed in multiple PNMP Clinic Minutes; and ▪ Criteria should be developed for assignment of priority level for wheelchair mat assessment. The document Wheelchair Consults by Priority, dated 1/6/11, identified the following categories of individuals who were experiencing significant delays in the provision of a new wheelchair and required wheelchair parts: ▪ Individuals identified at high priority for a new wheelchair and/or identified wheelchair part; ▪ Individuals reviewed by the Core NMT; and ▪ Individuals who were enterally nourished and identified at high risk for aspiration pneumonia. An individual might be listed more than one time in the following chart due to multiple "items needed":	

Individuals Identified at High Priority for Provision of Wheelchair		
Individual	**# of Days in Process**	**Priority**
Individual #215	498	High
Individual #67	415	High
Individual #67	232	High
Individual #221	357	High
Individual #155	308	High
Individual #91	679	High
Individual #91	308	High
Individual #315	287	High
Individuals Reviewed by the Core PNMT		
Individual #207	49	Medium

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		(see table below)	

Individual #207	83	Medium
Individual #160	287	Low
Individual #160	287	Low
Individual #160	239	Low
Individual #139	392	Low
Individuals Who Were Enterally Nourished and Identified at High Risk for Aspiration Pneumonia in excess of 100 days		
Individual #155	308	High
Individual #315	287	High
Individual #151	311	Medium
Individual #111	980	Medium
Individual #145	576	Low
Individual #154	198	Low
Individual #205	108	Low
Individual #57	189	Low
Individual #160	287	Low
Individual #134	134	Low
Individual #113	469	Low
Individual #292	196	Low
Individual #327	133	Low
Individual #293	162	Low
Individual #139	392	Low

The Purchase Request Tracking Format documented an order submitted to a company providing seating frames on 1/10/10, and an additional order submitted on 8/23/10. To date, these orders had not been fulfilled. This delay, in obtaining seating frames, was discussed during the Monitoring Team's visit, and the recommendation was made to address and resolve the significant delay in receiving seating frames as soon as possible.

Procedures should be developed for tracking the delivery of wheelchairs to address the following:

- Reevaluation of the criteria for identification of priority level for the provision of wheelchairs, including but not limited to, individuals reviewed by the Core PNMT, individuals receiving enteral nutrition, and individuals identified at high risk for skin breakdown;
- Establishment of timelines for the provision of new wheelchairs and/or parts as well as modifications to a wheelchair;
- Completion of an audit to determine compliance with established timelines; and

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		▪ Provision for the resolution and/or justification for why timelines were exceeded. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (as discussed further with regard to Section O.5 of the SA). Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (as discussed further with regard to Section O.4 of the SA). Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. As discussed above, adequate safeguards were not in place to ensure each individual had appropriate adaptive and assistive technology supports. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs (as discussed further with regard to Section O.5 of the SA). As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff on person-specific plans was not being completed. Data collection method is validated by the program's author(s). Due to the absence of plans as documented above, the data collection method could not be validated by the program's author.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Once the Habilitation Therapies Department completes its staffing analysis, Facility Administration should provide support to the Habilitation Therapies Department to address the findings. As appropriate, the realignment of positions should be considered to support reasonable SLP staff-to-individuals caseloads based on information gained from the analysis.
2. The Facility should develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines as outlined in the OT/PT evaluation template, which would also include the inclusion of significant medical issues and health risk indicators in a clinically justified manner.
3. Procedures should be developed and implemented to define the update process to be followed when an individual experiences a change in status.
4. PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training with specific learning objectives and identified competencies. Such training should include foundational knowledge and skills related to the appropriate implementation of physical assistance supports including, but not limited to: risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include skills-based performance check-offs. Therapists should conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required.
5. Procedures should be developed and implemented for tracking the delivery of wheelchairs to address the following:
    a. Reevaluation of the criteria for identification of priority levels for the provision of wheelchairs, including but not limited to, individuals reviewed by the Core PNMT; individuals receiving enteral nutrition, and individuals identified at high risk for skin breakdown;
    b. Establishment of timelines for the provision of new wheelchairs and/or parts, as well as modifications to a wheelchair;
    c. Completion of an audit to determine compliance with established timelines; and
    d. Provision for the resolution and/or justification for why timelines were exceeded.
6. Guidelines for the PNMP Clinic should be developed and implemented, including but not limited to, ensure the following:
    a. Therapist's signatures document their PNMP Clinic attendance;
    b. All PNMP prescribed assistive equipment will be assessed on an annual basis for fit, availability, function, condition, and effectiveness;
    c. A documentation process is established for resolution of problems with fit, availability, function, and condition of prescribed equipment;
    d. PNMPs incorporate prescribed footwear as discussed in multiple PNMP Clinic Minutes; and
    e. Criteria are identified for assignment of priority level for wheelchair mat assessment.
7. PNMPs should incorporate the wearing of shoes to support the importance of individuals wearing shoes.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Individuals identified to have missed dental appointments between 7/1/10 and 12/31/10, report generated 11/19/10; o CCSSLC Current Oral Hygiene Ratings, dated 1/5/11; o Plaque Index (purpose, selection, procedure, criteria, scoring, substitutions); o Individuals identified to have required extractions between 7/1/10 and 12/31/10, report generated 11/19/10; o Individuals identified to have required emergency dental treatment between 7/1/10 and 12/31/10, report generated 11/19/10; o Individuals identified to have required emergency dental treatment between 7/1/10 and 12/25/10, report generated 1/4/11; o Individuals identified to have refused dental treatment between 7/1/10 and 12/31/10, report generated 11/19/10; o Dental appointments cancelled between 7/1/10 and 12/21/10, report generated 12/27/10; o Facility policy: Quality Assurance: Participating in Performance Improvement Team (PIT) Monthly Meeting, approved 11/5/10, implementation 12/5/10; o Facility policy: Quality Assurance E.6: Operationalizing Daily Data Reports, approved 11/5/10, implementation 12/5/10; o Integrated Clinical Services Policy G.4: Using Shared Client Information Folders to Sustain Communication Between Disciplines, draft dated 12/15/10; o CCSSLC Dental Services Department monthly trend report from 10/1/10 through 10/31/10; o CCSSLC Dental Department monthly trending report from 7/1/10 through 12/25/10, report generated 1/3/11; o CCSSLC individuals that required dental sedation in 2009 and 2010, dated 12/30/10; o Desensitization Plans; o CCSSLC Current Oral Hygiene Rating - Poor, dated 11/24/10; o Desensitization List 11/2/10: Based on recommendation, dental assessments are being mailed to Psychology Department, based on sedation needs and tooth brushing needs; o CCSSLC Dental Database Desensitization Referral Part 1, and Part 2, dated 12/30/10; o Individuals sedated for dental appointments, dated 1/6/11; o FY 2010 Restraint Monthly Tracking log for August, September, October, November, December; o Individuals identified for preventative dental care between 7/1/10 and 12/31/10, dated 11/23/10; o Preventative Care Provided between 7/1/10 and 12/25/10, dated 1/4/11; o Dental Database Annual Exams Due September, October, and November 2010, dated 11/19/10;

	○ CCSSLC Dental Database 2011 recall due month, September 2010 through December 2010, dated 12/27/10; ○ CCSSLC Dental Database recall due month, January 2010 through August 2010, dated 12/27/10; ○ CCSSLC Dental Database 2011 recall month Due or Delinquent, dated 12/30/10; ○ Individuals identified for restorative dental work between 7/1/10 and 12/31/10, dated 11/19/10; ○ Dental records for Individual #38, Individual #255, Individual #295, Individual #325, Individual #323, Individual #251, Individual #67, Individual #366, Individual #176, Individual #313, Individual #62, Individual #277, Individual #318, Individual #114, Individual #236, Individual #237, Individual #368, Individual #166, Individual #240, Individual #124, Individual #363, Individual #348, Individual #136, and Individual #22; ○ Individuals sedated for dental appointments between 6/1/10 and 12/6/10, dated 12/13/10; ○ Sedation Usage Report between 6/1/10 and 11/16/10, dated 11/18/10; ○ Sedation Usage Report between 9/28/10 and 12/21/10, dated 12/27/10; ○ Individuals sedated for dental appointments – TIVA [Total Intravenous Anesthesia] usage, dated 1/4/11; ○ Individuals who have not seen dentist in one year from September to December 2010, and January to August 2010, dated 1/3/11; ○ Residence/dental schedule of appointments for individuals on October 26, 27, and 28, 2010; ○ Incident Management Review Team (IMRT) Meeting handouts from 10/27/10 for the Pacific Unit and Coral Sea Unit, and from 10/28/10 for the Pacific Unit; ○ Email dated 9/20/10 from Dental Department to Unit Directors, RNs, and QMRPs; ○ Email dated 12/22/10 from Administration to Unit Directors and Unit Secretaries; ○ Email dated 9/29/10 from Dental Department to Nursing Department re: "gum bleeding"; ○ Email from Dental Department "list of nominees who could benefit from a desensitization program to help with tooth brushing and dental sedations," including 11/2/10 10:52 a.m. Pacific desensitization, 11/2/10 11:04 a.m. Tropical desensitization, 11/2/10 11:16 a.m. Atlantic desensitization, 11/2/10 11:25 a.m. Coral Sea desensitization, 11/3/10 3:54 p.m. Coral Sea desensitization, and 11/3/10 4:06 p.m. Tropical desensitization; ○ Email from Psychology Department to Dental Department dated 12/12/10 re: desensitization plans; ○ Email from Administration dated 11/3/10 re: desensitization; ○ Treatment log for the month of December 2010; ○ Individuals identified to have missed dental appointments between 7/1/10 and 12/25/10, dated 1/3/11, with hand written description of type of appointment missed; ○ Dental Conference Call, dated 11/18/10; ○ Copy of PowerPoint presentation given by dental staff for residential oral care for individuals; ○ Request to post/training roster Course Title: Oral Care for Individuals (staff) 10/1/10

		(1300 hours, and 1400 hours), 10/8/10 (0600 hours, and 1400 hours), 10/15/10 (1400 hours), 10/22/10 (hour not submitted), 11/5/10 (1330 hours), 11/12/10 (0945 hours, 1415 hours), 11/9/10 (hour not submitted), 12/3/10 (hour not submitted), 12/9/10 (0630 hours); o Incident Management Review Team Meeting, Tropical Unit, 11/3/10, handout: "scheduled on campus medical and dental appointments;" o Plan of Improvement/Self Assessment on Section Q - Dental Services, dated 1/11; o Texas Health Monitoring Instrument SA.II.Q – Dental Services, dated 10/12/10, 10/26/10, and 12/6/10; o Annual dental summaries for the following individuals: Individual #297's annual dental summaries dated 2/8/10, and 12/2/10; Individual #131's annual dental summaries dated 1/7/10, and 12/8/10; Individual #302's annual dental summaries dated 12/17/09, and 11/30/10; Individual #339's annual dental summaries dated 1/14/10, and 12/3/10; Individual #340's annual dental summaries dated 10/27/09, and 11/18/10; Individual #355's annual dental summaries dated 2/1/10, and 11/17/10; Individual #212's annual dental summaries dated 12/2/09, and 10/15/10; Individual #183 's annual dental summaries dated 3/10/10, and 12/10/10; Individual #3 's annual dental summaries dated 12/11/09, and 10/6/10; Individual #310's annual dental summaries dated 7/29/10, and 11/29/10; Individual #326's annual dental summaries dated 1/25/10, and 12/6/10; Individual #6's annual dental summaries dated 11/16/09, and 11/2/10; Individual #150's annual dental summaries dated 1/12/10, and 12/15/10); Individual #319's annual dental summaries dated 1/12/10, and 12/2/10; Individual #300's annual dental summaries dated 1/12/10, and 11/2/10; Individual #333's annual dental summaries dated 5/10/10, and 11/16/10; Individual #363's annual dental summaries dated 1/13/10, and 11/30/10; Individual #112's annual dental summaries dated 2/22/10, and 11/19/10; Individual #202's annual dental summaries dated 5/11/10, and 11/16/10; Individual #293's annual dental summaries dated 1/27/10, and 11/16/10; Individual #237's annual dental summaries dated 11/30/09, and 10/28/10; Individual #187's annual dental summaries dated 2/22/10, and 10/11/10; Individual #201's annual dental summaries dated 7/20/10, and 11/1/10; Individual #231's annual dental summaries dated 1/22/10, and 12/20/10; Individual #156's annual dental summaries dated 2/1/10, and 12/17/10; Individual #138's annual dental summaries dated 9/14/09, and 9/09/10; Individual #46's annual dental summaries dated 1/4/10, and 12/13/10; Individual #179's annual dental summaries dated 11/2/09, and 12/20/10; Individual #269's annual dental summaries dated 10/21/09, and 11/18/10; Individual #364's annual dental summaries dated 9/28/09, and 12/2/10; and Individual #182's annual dental summaries dated 10/6/09, and 11/2/10; o DADS Policy #015: Dental Services, dated 8/17/10; o Facility Policies XIV.1 Dental Services, including: • Q.1: Parenteral Sedation Intravenous (IV) (TIVA or MAC [Monitored Anesthesia Care]) Anesthesia, approved 11/8/10, implementation 12/8/10; • Q.2: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Criteria for

	Use, approved 11/8/10, implementation 12/8/10; • Q.3: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Medical Clearance, approved 11/8/10, implementation 12/8/10; • Q.4: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Dentist Anesthesiologist, approved 11/8/10, implementation 12/8/10; • Q.5: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Surgery, approved 11/8/10, implementation 12/5/10; • Q.6: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia - Anesthesiology Personnel, approved 11/8/10, implementation 12/8/10; • Q.7: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Pre-operative Sedation prior to TIVA or MAC Sedation, approved 11/8/10, implementation 12/8/10; • Q.8: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Recovery, approved 11/8/10, implementation 12/8/10; • Q.9: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – REACT [Respiration, Energy, Alertness, Circulation, and Temperature] Scoring System, Vital Signs Flow Sheet, implementation 12/8/10; • Q.10: Missed or Refused Dental Appointments – Criteria for Use, approved 11/8/10, implementation 12/8/10; • Q.11: Monitoring of Pre-Post Dental Sedation – Criteria for Use, approved 11/8/10, implementation 12/8/10; and • Q.12: Consultations – Dental, approved 11/8/10, implementation 12/8/10; o Facility policies pending approval: Dental Care Services: Assurance, Standard of Care, Initial Dental Examination, Annual Dental Examination, Direct Care Professional Training, Desensitization, and Chemical Intervention Protocol Working Draft. ▪ **Interviews with**: o Enrique Venegas, DDS, Dental Director
	Facility Self-Assessment: The Facility's POI identified that it remained out of compliance with both sub-provisions of Section Q. This was consistent with the Monitoring Team's findings. In the narrative portion of the POI, the Facility noted a number of initiatives that had been undertaken to move towards compliance. On a very positive note, in addition to narrative information, the Facility cited data that was obtained through its own self-assessment monitoring activities. For example, three samples of individuals' records had been reviewed to determine compliance with annual dental examinations, numbers of missed appointments, and reasons for the missed appointments. These samples were reviewed in October (two samples) and December (one sample). A "mini audit" also was completed in December to determine the outstanding number of annual assessments. This process illustrated good use of objective data to assist the Facility in determining whether or not it was in substantial compliance with the Settlement Agreement. These efforts should continue to be expanded to include more of the components necessary to substantiate the provision of adequate dental care (e.g., emergency care, restorative care, etc.), as well as to review the quality of the dental services being provided and the outcomes being achieved for individuals (e.g.,

	improved oral hygiene index scores).
	Summary of Monitor's Assessment: The Facility's Dental Department had made great strides in the past six months. At the time of the most recent review, the Dental Department had a full complement of staff, including two dentists. The oral hygiene index scores, which were a key indicator of individuals' dental health, had improved across the campus. There were only three individuals who had not completed an annual dental assessment, which was a significant improvement since the last review. There had been energy and creativity devoted to reducing the missed appointment rates, including: ▪ Staff from the Dental Department were attending some individuals' PST meetings to brainstorm ways to reduce the refusal rate; ▪ A database with reliable information had been developed. To ensure quality information, only dental staff completed database management tasks. The Department had begun the challenge of categorizing refusals. However, there remained a significant number of missed appointments for unknown reasons; and ▪ To minimize chronic refusals and missed appointments, the dentist was completing annual assessments in the residence, for certain individuals. Extensive training was being provided to direct support professionals on how to best assist individuals in their residences with tooth brushing. During observations in the residences, it is evident the oral hygiene was excellent in many cases, due to the Dental Department having two technicians dedicated to tooth brushing with prescription treatment, as well as teaching the direct support professionals about the oral hygiene needs of the individuals. Challenges remained, including not identifying the reason for refusals and missed appointments, as well as the lack of implementation of desensitization programs, although plans had been written. Plans also had not been written for individuals who had required physical restraints in order for dental work to be completed. Desensitization plans are a key component to reducing the need for the extraction of multiple teeth, due to decay, as was seen for a number of individuals in the sample reviewed. Concerns also were noted with regard to pain management of individuals with emergency dental treatment needs, as well as timely care or follow-up for these individuals. The dental peer review group, which included dentists from all of the SSLCs, had not agreed upon an oral health index to use. This would be important to finalize in the near future. The Dental Department remained noncompliant with this Section of the Settlement Agreement, but continued to make significant advances toward compliance.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In the Dental Department, there were two dentists, two dental hygienists, two dental technicians and one dental assistant. This represented a full complement of staff. The Facility's Systems Analyst had created an Access database, which was lauded as being invaluable to the Dental Department. Prior to the creation of this database, there were two different databases and the information was not consistent across the databases, making the information unreliable. As of 9/1/10, a single database was implemented, and it had impressive effects on the quality of information the Dental Department generated. With the new system, only Dental Department staff were allowed to enter data. Separately, a monthly, independent treatment log was maintained as a way to check the accuracy of information in the new Access database. The Dental Department also had developed a database to assist in tracking individuals' scores on the oral hygiene index. As part of the oral health program, the Dental Department created a PowerPoint teaching program for the direct support professionals. This presentation was followed by one-on-one training to ensure staff were competent in understanding and implementing tooth brushing for the individuals. The program was started in the Coral Sea Unit, and at the time of the Monitoring Team's visit, the teaching occurred each Friday at the change of each shift. As of 12/13/10, 50 staff in Coral Sea had been trained using the Power Point program. A number of training rosters were submitted verifying the training dates for "Oral Care for Individuals (staff)." Dates submitted were 10/1/10 (1300 hours, and 1400 hours), 10/8/10 (0600 hours, and 1400 hours), 10/15/10 (1400 hours), 10/22/10 (no time recorded), 11/5/10 (1330 hours), 11/12/10 (0945 hours, and 1415 hours), 11/19/10 (no time recorded), 12/3/10 (no time recorded), and 12/9/10 (0630 hours). Important topics surfaced during these educational outreach opportunities and improved dialogue had begun between departments. For instance, staff had been reluctant to brush the teeth of some individuals because it caused profuse bleeding. Staff had the misunderstanding that the treatment was harmful, and additionally, nursing staff would contact the Dental Department for an emergency visit based on bleeding gums from tooth brushing. In December, the dentists had begun meeting with the PSTs to inform them that this was not considered an injury, or an emergency, but anticipated sequelae of brushing, which would lead to improved oral hygiene. The dentists explained that not brushing would only lead to worsening oral health. As a follow-up, the dentist was to see the employee with the assigned individual in the clinic for further training. With improvement in oral hygiene and gradual acceptance of tooth brushing with familiar staff, it was anticipated that there also would be improved cooperation from the individual in the dental office. Unfortunately, the Dental Department reported that there were many times when staff that accompanied the individual did not work with the individual on a regular basis, negating the full effect of the follow-up visit.	Noncompliance

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		Each individual was assigned a score indicating the health of the gingival tissue and plaque formation. There were four levels of gradation (1 = good, 2 = fair, 3 = poor, and 4 = very poor). These were based on the dental hygienist's assessment during prophylactic treatment. The scoring was based on the Plaque Index. The scoring system was not standardized across the State. Through the dental peer process, it would be valuable to agree upon and utilize one standard index. This was discussed at a Dental Conference Call on November 18, 2010, but a decision was not reached. At the time of the review, the oral hygiene scores the Facility provided indicated that 72 individuals were considered to have good oral hygiene, 106 had fair oral hygiene, 75 had poor oral hygiene, and the remaining 31 individuals had very poor oral hygiene. In a separate document entitled "CCSSLC Current Oral Hygiene Rating – Poor," dated 11/24/10, 78 individuals were listed as having a poor oral hygiene rating. This was consistent with the prior mentioned report data of 1/05/11, and indicated continuing improvement. Just six months ago, during the Monitoring Team's last visit, there were approximately 130 individuals with a score of 4. This was impressively reduced to 31. The goal will be to continually increase the numbers of individuals in the good and fair categories. A list of those individuals for whom a preventive dental care visit was completed was submitted. The report was entitled "Individuals Identified for Preventative Dental Care between 7/1/10 and 12/31/10." It totaled 131 individuals. However, the report was generated on 11/23/10, and represented almost five months of dental visits in this category, as opposed to six months. Based on a population of 283 individuals, this was 46% of the individuals living on campus. Nineteen individuals were identified with the comment "unsuccessful," which appeared to indicate refusal of attempts to complete x-rays. An updated report, "Preventative Care Provided Between 7/1/0 - 12/25/10", was generated on 1/4/11. In this report, there were 159 individuals who had undergone preventative care over six months, which was consistent with the earlier report. A report was submitted entitled "Individuals Identified for Restorative Dental Work between 7/1/10 - 12/31/10." However, the report was generated on 11/19/10. During this time, 19 individuals attended 22 dental visits for restorative care. One visit for Individual #114 (appointment date 10/11/10) was also listed as an emergency dental visit. A list of those individuals that required extractions from 7/1/10 through 12/31/10, dated 11/19/10, was submitted. During this time, 11 individuals completed dental extractions. One of these individuals underwent two visits for extractions, on 7/13/10 and 9/15/10.	

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		A list of those individuals that required emergency dental treatment between 7/1/10 and 12/31/10, dated 11/19/10, was submitted. During this time, 16 individuals had emergency visits. Three of these individuals were seen for two emergency visits. Individual #38 was seen twice, and the emergency visits were approximately one week apart on 7/6/10, and 7/13/10. For Individual #114, the two emergency visits were separated by approximately two months on 8/13/10, and 10/11/10. For Individual #27, the two appointments were separated by approximately one month on 9/10/10, and 10/18/10. A second list of individuals that required emergency dental treatment between 7/1/10 and 12/31/10 was submitted, and this report was generated on 1/4/11. On this list, there were 18 individuals identified. Of these, the two visits of Individual #38 and Individual #114 were again documented, but the two appointments for Individual #27 were not listed. This discrepancy highlighted the need for the database entries to be reviewed so as to minimize discrepancies. For emergency visits, a number of dental progress notes were reviewed to determine promptness of treatment, quality of care, and closure of the concern identified. From review of 10 individuals' records, there were concerns related to pain management or documentation in five of them (50%). The following provide examples: ▪ Individual #38 was seen on an emergency basis on 7/6/10, and for follow-up on 7/13/10 for mouth lesions. An exam was documented, and medication prescribed. A follow-up visit was recorded for a repeat exam to ensure healing. ▪ Individual #255 told dental staff that while in his residence he had a chipped tooth. This occurred on 7/13/10. An emergency exam was scheduled on Friday 7/16/10. The chipped area was smoothed and polished. The treatment was appropriate. There was concern, though, that it took three business days for the visit to occur. There was no indication as to why the individual was not seen later that day or the next day. If there are delays in seeing the individual in the office once the Dental Department is informed of an emergency, then there should be documentation of the reason for a delay, such as the individual refused, all appointment slots filled, etc. If the condition is considered an emergency, it should be dealt with promptly. ▪ Individual #325 was seen on 9/17/10 for soreness of a tooth. A filling was removed, but no decay was found. A new filling was placed. Then, on 9/29/10, he was seen for continued discomfort of that tooth. An x-ray, taken on 9/17/10, was reviewed, but did not reveal any pathology. An antibiotic was prescribed for possible pulpitis, and he was to be re-evaluated after completion of the antibiotic. Subsequently, on 10/8/10, he was seen on an emergency basis for continued pain. A repeat x-ray was taken and reviewed. Two teeth had negative	

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		findings. He was referred to the oral surgeon. Based on the submitted documents, there was no indication that pain or comfort medication was prescribed until the oral surgeon could see him. ▪ Individual #251 was seen on an emergency basis on 9/29/10 for a toothache, and examination revealed a fractured root. She was scheduled for an extraction, and was already on an antibiotic for another infection. No pain or comfort medication was prescribed. Based on the list entitled "Individuals Identified to have required extractions," this individual was listed as having had an extraction on 11/15/10. Based on the documentation submitted, there was no reason provided for the delay in treatment of her toothache, especially since no pain medication was prescribed, nor was there any information recorded to indicate the pain had resolved with the antibiotic she had been taking. When an individual is identified with dental pain, there should be documentation that the Dental Department tracked this and resolved it expeditiously. ▪ Individual #366 was seen on 8/9/10 for lesions in his mouth. A large ulcer was found on his tongue and was treated with a surgical dressing, with a plan to re-evaluate in three to four days. There was no further entry submitted indicating that the re-evaluation occurred in three to four days. ▪ Individual #313 was seen on 11/29/10 for an emergency visit. There was a sore area on the tongue. A thorough evaluation was recorded. She was to be re-evaluated in two weeks. She was then seen on 12/13/10. The lesion was still present. She was referred to the oral surgeon for a biopsy, which was scheduled for 1/21/11. ▪ Individual #62 was seen for pain on 7/8/10. He was examined, but the pain could not be reproduced. He was prescribed an antibiotic. He already had a follow-up appointment scheduled with a specialist later that month. ▪ Individual #277 had an emergency visit on 7/13/10, because he stated his tooth fell out. There was no pain. X-rays were taken and the tooth was "badly broken down." He was already on antibiotics. He was referred to the oral surgeon. ▪ Individual #318 was seen on 9/8/10 for an emergency visit for sore gums. X-rays could not be taken due to dental construction. While at the dental office, the individual stated that he was not in discomfort. The dental note only indicated some slight to moderate calculus, plaque, and bleeding. The charting was difficult to interpret, because this was followed by a note recorded as 8/26/10 indicating a nurse had stopped at the clinic and informed staff of this individual's sore gums. A 9/23/10 note followed this one, and it described an emergency "loose feeling cavity." This was followed by a comment that the residence was being fogged for pest control. There was no further information submitted to indicate that this "loose feeling cavity" was addressed. The lack of chronology of the notes, and the lack of information about the follow-up to the emergency visit of 9/23/10 were problematic.	

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		▪ Individual #114 underwent an emergency dental visit on 8/13/10 for a lost filling. A temporary filling was placed, and he was to return for a composite. This was done on 9/22/10. He underwent a second emergency dental visit on 10/11/10, and a broken composite was found on a different tooth, which was replaced at that time. The Dental Department worked collaboratively with an oral surgeon, and a referral system was in place and was highly successful. Records for those undergoing oral surgery for the six months prior to the Monitoring Team's visit were reviewed. The following provide examples: ▪ On 3/23/10, Individual #236 had an annual exam, and one tooth was extracted while under TIVA. She was then referred to the oral surgeon, and on 7/13/10, three teeth were removed under general anesthesia at the oral surgeon's office. An anesthesia report was provided to the Facility indicating the type of medication used and the dosage used. The Facility Director signed Authorization for Medical Treatment, as well as the Sedation/Protective Support Consent Form for Medical/Dental Procedures. ▪ Individual #176 received 0.5 mg Ativan one hour prior to his exam, but he was resistive to care. On 7/20/10, the consultant oral surgeon completed scaling and cleaning of Individual #176's teeth under general anesthesia at his private office. Individual #176 also had two teeth removed, and roots from 12 teeth removed. The Facility dentist completed a postoperative evaluation, and Individual #176 was placed on one-to-one supervision so his gums to heal. An anesthesia report indicated the types of medication given with dosages. A copy of the anesthesia record also was provided to the Facility. Prior to the procedure, the Facility physician was consulted and Individual #176 was referred to cardiology for clearance. The Facility physician provided a verbal medical clearance. A letter from the Dental Director was sent to the sister/guardian with an explanation of the need for oral surgery and that cardiology clearance had been obtained. The guardian signed both the Consent to Treatment – Therapy – Surgical Procedure and Sedation/Protective Support Consent Form for Medical/Dental Procedures. ▪ Individual #368 underwent oral surgery on 8/16/10, for removal of two teeth under IV sedation. An anesthesia report was forwarded to the Facility, indicating the medication and dosage given during the procedure. Prior to the procedure, a letter was sent to the mother/guardian explaining the reason for the procedure. The mother/guardian signed the Consent to Treatment – Therapy – Surgical Procedure as well as Sedation/Protective Support Consent Form for Medical/Dental Procedures. ▪ Individual #237 had general anesthesia for oral surgery on 10/12/10. Four teeth and residual tooth roots of a fifth tooth were removed, as well as an	

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		exostosis. An anesthesia report included the medication used and the dosage used. The Facility Director signed consents. ▪ The Dental Director attended a PST meeting for Individual #166 on 10/1/10 to discuss his upcoming surgery. On 10/19/10, he underwent oral surgery with general anesthesia for removal of 16 teeth and one root tip from a 17th tooth. An anesthesia report was provided with medication and dosage used. A letter was sent to the father/guardian explaining the reason for the procedure, and the father signed two consent forms. These cases demonstrated the rigorous and effective protocol the Facility used to provide needed oral surgery. Letters were sent to the family/guardian explaining the reason for the oral surgery, medical clearance was obtained, when indicated, and efforts were made to ensure consents were signed in a timely manner. Of concern was the removal of numerous teeth, at once, in some of these examples. Although this was necessary under the circumstances, it indicated the need for improved oral hygiene, and effective desensitization plans to ensure such severe decay does not continue to occur. A highly successful dental program should theoretically have less tooth extraction over time, and more tooth restoration. It also was concerning that two out of these five cases had no guardian or health care representative. As is discussed in further detail with regard to Section U of the Settlement Agreement, there is need for a methodical approach to obtain guardians or health care representatives for those who do not have such representatives.	
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;	This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include annual examinations and assessments, refusals and missed appointments, interventions to minimize the use of sedating medications, tracking of use of sedating medications and restraints, and the development of dental policies and procedures. Annual Examinations and Assessments The Dental Department had made some significant changes in ensuring annual assessments were accomplished in a timely manner. The goal was shifted to complete the annual assessments by the end of the eleventh month, leaving a period of 30 days to follow up with those individuals who refused or were "no shows." In order to accomplish this, appointments were made up to 60 days prior to the due date. Additionally, the Friday appointment schedule was used as a make-up day for missed appointments. The Dental Department also made a decision to make visits to the residences for those individuals who refused to attend the dental clinic or were unable to leave their residences. Additional steps taken included reminding the residential units of the campus calendar, and calling the residences on the morning of the dental appointment.	Noncompliance

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	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.	This resulted in considerable success. There were several individuals who refused to come to the dental office for various reasons. In these instances, a dentist made a visit to the residence to complete the annual exam. At the time of the review, an annual assessment remained outstanding for only three individuals. The Dental Department submitted a list of those annual examinations due September to November 2010, and three individuals were listed as past due: Individual #295, Individual #67, and Individual #106. Everyone else on the list, for annual examinations due August through November, appeared to have had an examination completed in a timely manner. In an updated document listing completion of annual examinations (report generated 1/3/11), three individuals were listed, including Individual #295 and Individual #67, but Individual #106 was listed as completed, and Individual #323 was listed as overdue for an annual examination. The reason for the discrepancy was not provided. Individual #295 and Individual #67 were due in August 2010, and Individual #323 was due in March 2010. The dental records for these three individuals were reviewed to obtain the history and to determine the number of attempts made to complete office visits. The following summarizes the results: ▪ For Individual #295, on 3/26/10, he was given Ativan 2 mg an hour before the visit, but he could only cooperate for a brief time. He also was noted to be very unsteady on his feet. He was considered a possible candidate for TIVA. He was considered a "no show" on 4/14/10, and refused an appointment on 6/1/10, as he wanted to go to work. He refused his annual exam on 8/9/10, and he refused a rescheduled annual and prophylactic visit on 10/18/10. No reason was documented for not following up on the consideration of TIVA. The Dental Department had scheduled four appointments for which he did not show. There was no information about whether the PST had addressed this issue, and whether there was a way for him to attend work, but at some point during the week, have his dental evaluation completed. ▪ For Individual #67, on 8/20/10, the annual exam was actually attempted in the residence, but she already had left for work. On 10/5/10, she was scheduled for an appointment with TIVA, but was awaiting the Family Nurse Practitioner's (FNP's) approval. She was scheduled for an 11/9/10 appointment, but unfortunately, the medical clearance had not been completed. Then, on 12/8/10, she was again scheduled for TIVA, but her residence was under isolation, and the visit did not occur. It is impressive that the Dental Department actually made a trip to the residence to complete her annual assessment. The next step, TIVA, might have been deferred if the dental team could meet her in the residence before or after work. Again, the PST would be the best group to determine a plan, in which case TIVA might be avoidable. Unfortunately, the plans for TIVA were also changed. The reason for the delay in the medical	

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		clearance was not documented. It would be important to begin to record the reason for the delays in medical clearance. There could be many reasons, and if a trend was found, then this would be an issue requiring resolution. ▪ Individual #323 did not arrive for his annual exam on 10/27/08. He refused an appointment for his annual and prophylactic appointment on 3/23/09. He was seen for an annual exam on 7/10/09. On 1/15/10, he did not show for a prophylactic treatment, and refused appointments on 3/10/10, and 5/10/10. He did not arrive for his annual exam and prophylactic treatment on 7/26/10, and an appointment on 9/8/10 for annual and prophylactic treatment was not kept because he was on furlough. When the Dental Department called his residence to confirm a rescheduled annual and prophylactic treatment on 11/29/10, the answer was that he was still on furlough. There was no documentation of any steps the PST had taken to reduce the chronic refusals and no shows. It also would be more efficient for the Dental Department to learn of those on furlough ahead of time, so that the appointment time could be used to accomplish other tasks. There was no documentation regarding the next steps to be taken to assist in resolving his chronic refusal to attend dental clinic. Timeliness of annual dental summaries was reviewed in a submitted sample of recent annual assessments. For 27 out of 31 records reviewed (87%), there was compliance with timely annual dental summaries. Those that had timely annual dental summaries (within 365 days of the prior annual dental summary) included: Individual #297, Individual #131, Individual #302, Individual #339, Individual #340, Individual #355, Individual #212, Individual #183, Individual #3, Individual #310, Individual #326, Individual #6, Individual #150, Individual #319, Individual #300, Individual #333, Individual #363, Individual #112, Individual #202, Individual #293, Individual #237, Individual #187, Individual #201, Individual #231, Individual #156, Individual #138, and Individual #46. Those individuals for which the annual dental summaries were beyond the 365-day interval included: Individual #179, Individual #269, Individual #364, and Individual #182. Two of the individuals, Individual #310, and Individual #333, had annuals close together, which seemed redundant. Individual #310 had annual examinations four months apart, and Individual #333 had annual examinations six months apart. Refusals and Missed Appointments As mentioned previously, the two databases that previously had caused confusion, had been replaced with one database system. The new database provided considerable clarity and more accurate information. As a result, the Dental Department was able to begin to reliably determine trends, and address the many issues outlined in prior	

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		reports. A document was submitted entitled "Individuals Identified to have Missed Dental Appointments between 7/1/10 and 12/31/10." It was generated on 11/19/10, resulting in approximately four and a half months of data, rather than six months. During these four and a half months: ▪ There were 156 missed appointments recorded. ▪ A total of 121 individuals out of 283 individuals missed an appointment during this time period. ▪ Twenty individuals missed two appointments, four missed three appointments, and one missed four appointments. ▪ The category for "reason" was extensive, and provided evidence that the Dental Department was beginning to look at the many reasons for a missed appointment. For example: o Eighteen missed appointments were due to refusals (12%). o Thirty missed appointments were due to dental clinic issues (19%). o Twenty-four were due to individuals being sick (15%). o Additionally, 18 missed appointments were due to staffing issues in the residence (12%). o Nine were due to problems of medical clearance (6%). o Twenty-nine remained unknown (18%). For refusals, the information was available through a shared folder intranet system. Through this system, Residential Units and QMRPs were aware when an individual missed an appointment. Additionally, this information was shared in a 24-hour report. To ensure system integrity, only the Dental Department staff entered data. According to a Facility policy: Quality Assurance: Operationalizing Daily Data Reports, the Systems Analyst was responsible for "ensuring the oversight reports are generated daily before the opening of business at 8 a.m. for: Trend reports for PIT, CCSSLC missed dental appointment reports, and overnight dental no show reports." Presumably, this information was discussed at the next daily unit meeting. This system started in October 2010, but there was no information provided about whether or not this information was discussed at the meetings, and/or if action steps were agreed upon and implemented. It is recommended that a system of feedback be created to ensure the Dental Department is made aware of progress or obstacles in reducing the recurrence of refusals of specific individuals. This would allow the Dental Department to prioritize which individuals' teams needed their assistance at PSTs to discuss options and implementation action steps. The Facility policy Quality Assurance: Participating in Performance Improvement Team	

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		(PIT) Monthly Meeting, outlined a quality assurance pathway, which, if implemented, would assist the Dental Department in reducing missed dental appointments. The policy stated: "The Unit Director reviews monthly Trend Report data for each home in the following areas with the QMRP and Unit Coordinators and recommends improvement options if needed: … Number of missed dental appointments…" The role of the Unit Director also was outlined in the Operationalizing Daily Data Reports, in which the Unit Director (or designee) was to ensure the team discussed the relevant issues from these reports and provided an action plan to resolve the problem. Additionally, "the RN Manager reviews monthly data for each home in the following areas and recommends improvement options if needed: … number of individuals who missed one or more medical or dental appointments in a floating 30 day [period]…" According, to the policy, the Unit Director and RN manager would bring their reports to the meeting for distribution, discuss them, and determinate if there was any need for additional actions. If implemented, this policy should assist the Dental Department in reducing the no-show rate. Review of the implementation of this process demonstrated limited progress. Although it appeared the issues were being raised in the meetings, adequate follow-up activity was not documented. For example: ▪ In the 11/3/10 Tropical Unit Incident Management Review Team Meeting minutes, there were two individuals that missed dental appointments. For one, the reason was "out on furlough," and the response "was rescheduled." For anticipated conflicts, the residence should be expected to call the dental office the day prior to the appointment to reschedule, so the block of time reserved for the appointment can be utilized for other purposes. The other individual "refused to attend," and the same response "will be rescheduled" was provided. There was no documentation that the team discussed the reason for the refusal, and/or what steps could be taken to ensure a repeat refusal would not occur. ▪ Individual #130 had an appointment on 10/26/10. Based on the Unit Incident Management Review Team meeting minutes, he did not keep the appointment. The reason given was that he "was not on the calendar." An email had gone out the month prior alerting staff of the issue of appointments not being consistently on the calendar. There was no information regarding the steps that were being taken to prevent this from occurring repeatedly. It would have been helpful for the IMRT to assign a specific individual the responsibility of investigating the concern, with a follow up date for discussion of the next step. The IMRT report did not include such critical information. There were other documented steps to improve the show rate for dental appointments. On 9/20/10, an email went to appropriate administrative staff indicating that the dental	

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		staff noticed the DCP calendar did not have all appointments recorded. The email included a request to correct the issue. There was also an email from Administration to the Unit Directors and Unit Secretaries indicating that: "a random sample of Unit Morning Meeting Minutes… many of the sections related to reasons for missed dental/medical appointments are blank… they must be complete. In addition, you must have a documented plan in place to correct missed appointments such as refusals. You must also communicate with dental and medical staff when there is a systemic problem and what you are doing about it…" Backing from administration is imperative to ensuring communication and cooperation between departments. Emails such as this one should provide all involved departments motivation to assist in the resolution of identified issues. For missed appointments due to dental clinic issues, the main reason was renovations occurring in the dental clinic. This was a one -time event, and the number of missed appointments for dental clinic reasons should be reduced in the future. The renovations took longer than expected, and scheduled appointments had to be changed with little advance notice. Missed appointments for unknown reasons remained a substantial percentage of the total missed dental appointments. This had been a continued source of frustration. On the morning of each appointment, the Dental Department was calling the residence as a reminder. If the individual did not show for an appointment, another call was made to the residence. If there was no answer, calls were made every five minutes, if necessary, and as time allowed. Residential staff who answered the phone often were unable to provide a reason for the missed appointment, and the cause remained unknown. It is recommended that an email or written note be generated at the time of a "no show" with no known reason. This note should be sent to the QMRP for a response. The Dental Department could then track responses, and the unknown rate of refusals should decrease. Another group of "no shows" was labeled as "cancelled." At times, little additional information was shared with the Dental Department. However, on a list entitled Dental Appointments – Cancelled between 7/1/10 and 12/21/10, the Dental Department provided further categories for the cancellation, such as dental clinic issues (still somewhat vague), medical clearance, individual sick, staffing issues in the home, furlough, etc. To improve documentation, prior to the end of the day, dental staff were documenting "no shows" in the integrated progress notes, as well as the dental records.	

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		Missed appointments were rescheduled for all individuals. The length of time for the rescheduled appointment to occur varied, however, and at times was up to five months later. In a sample of 45 rescheduled appointments for missed visits, 12 occurred within one month, 12 occurred within two months, 13 occurred within three months, four occurred within four months, and two occurred within five months. Two individuals were transferred to other Facilities, and no information was available with regard to follow-up. The long delays, in rescheduling appointments for many of the individuals, were reviewed further. Some of these individuals participated in day programming, and had a set activity schedule. Individuals sometimes resisted changes in their established schedules. The follow-up appointment for these individuals was scheduled to occur simultaneously at their next upcoming annual exam. The intention was not to have two appointments within proximity, which would create potentially another refusal. However, it contributed to the long delay in rescheduling a visit (up to five months). The Dental Department schedule normally was full two months in advance, although they did leave Friday schedules flexible for those who missed appointments during the week. For a large facility setting, the lapse of time exceeding one to two months seemed excessive. The Dental Department should review the timeframe in which individuals are rescheduled, with a goal to reschedule appointments within 30 days of the missed appointment. Dental Department presence at the PST meetings would assist in brainstorming approaches to improve compliance for these individuals. Assistance from Psychology and other departments also will be important to improve the compliance rate for attendance at the dental clinic. Additionally, data regarding the type of visit that was missed (prophylactic, annual, restorative) was not available as part of the submitted computerized information. Handwritten entries providing the type of appointment were provided on a later copy. If this information was not available through the database, it would be an important data element to add. Tracking the type of appointment missed would assist the Dental Department and residential PST to identify and address any trends. In reviewing the handwritten entries, over the prior six month, 40 individuals missed an annual/prophylactic treatment appointment, 66 missed a prophylactic treatment appointment, 24 missed a restorative visit appointment, 17 missed an annual exam visit, and there were 18 other appointments missed. A document was submitted entitled "Individuals Identified to have refused Dental Treatment between 7/1/10 and 12/31/10," dated 11/19/10. This list totaled 22 individuals who refused a dental appointment. Two individuals refused an appointment twice. The reason for the refusal was only provided for five individuals (23%). To resolve refusals, the reasons need to be identified. This might best be left to the PST to	

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		investigate and provide options for resolution. To assist in resolving refusals, as well as cooperation with the dental exam and tooth brushing, as of 12/8/10, a dental representative began attending PST meetings. However, the percentage of PST meetings that a dental representative attended was not provided. The impact of some of the changes that had been made to the system was being tracked, and improvement had already occurred. The show rate before these interventions were implemented was 61% to 68%, and after the changes were made, the rates were up to 80% to 83%. Based on the Dental Services Department Monthly Trending Reports, the Dental Department began to break down the no shows and also, over time, to reduce the category "attendance not documented." From June 2010 to October 2010, the "attendance not documented" category was reduced from 17 to three appointments. The show rate for June 2010 was 60% and in October 2010, the show rate was 80%. An update in the monthly trending reports was submitted for November and December 2010. "Attendance not documented" for December was recorded as "0." The show rate peaked in November 2010, with an 84% show rate. In December 2010, it dropped to 77%. In order to provide further insight and information concerning any patterns of missed appointments, the Dental Department reviewed a number of graphs and pie charts. Graphs and pie charts for the months of July through December 2010 were submitted. The data review included a wide array of comparisons: shifts missing appointments, reasons appointments missed per shift, reasons appointments were missed, appointment attendance by unit, and appointment attendance by residence. An increase in missed appointments could be readily identified by such data, allowing the Dental Department to readily focus on problem areas. However, it was not clear what next steps were taken with this data. For example, it was unclear whether the data was discussed and action steps considered at a Dental Department meeting, or whether the Dental Director met with the Unit Director to discuss concerns with a particular home, or brought this information to a PST meeting for discussion. It is important to analyze data, develop and implement action steps, and document this process. <u>Interventions to Minimize the Use of Sedating Medications</u> An interdisciplinary committee, including the Psychology Department, PST members, the Medical Department, and the Dental Department, was created to focus on desensitization plans to reduce restraint use, reduce individuals' anxiety, and thereby reducing refusals and increasing cooperation with the dental visits. This committee was scheduled to meet on 12/16/10. In the sample submitted, recommendations for desensitization plans were included in	

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		the annual dental summary for a number of individuals, including: Individual #131, Individual #339, Individual #340, Individual #212, Individual #3, Individual #326, Individual #6, Individual #300, Individual #363, Individual #202, Individual #269, Individual #187, Individual #201, Individual #364, Individual #231, Individual #156, Individual #182, Individual #46, Individual 310, and Individual #333. These summaries were forwarded to the psychology staff and the QMRPs for their review. According to a document entitled "Desensitization Plans," 165 individuals were listed as having desensitization plans for medical or dental procedures. The date the plan was developed was recorded on all plans as 10/12/10, and the implementation date varied between 10/7/10 and 10/15/10. The date training was completed was 10/7/10 to 10/14/10 for some of the plans. Many of the plans had no training date recorded. Concerns related to the quality of the desensitization plans, which had been developed shortly before the Monitoring Team's onsite visit, are detailed with regard to Section C.4 and Section S of the Settlement Agreement. The Dental Department submitted a "Desensitization List 11/02/10" for those individuals referred to the Psychology Department for consideration of a desensitization plan. This was based on dental assessments, and included two categories of reasons for referral, a tooth brushing reason and a sedation reason. A total of 17 individuals were identified as needing a desensitization plan for tooth brushing, and a total of 32 individuals were identified as needing a desensitization plan for sedation reasons. On review of the list, although the number of tooth brushing referrals appeared accurate at 17, the number of those needing desensitization plans for sedation totaled 52, not 32. The reason for the difference in the count was not immediately clear. The referrals occurred between 11/2/10 and 12/22/10. There were three individuals listed from December without a referral date documented. In discussions with the Dental Director, the concern was raised that there had been a reticence from the Psychology Department to create desensitization plans for tooth brushing, and their focus was limited to those who required sedation. For those individuals with such tactile defensiveness or other behavioral issues related to dental care, lack of tooth brushing will lead to worsening oral hygiene, a challenge that the Dental Department was attempting to prevent. The Psychology Department should assist in the development of desensitization plans for this group of individuals as well. <u>Tracking of Use of Sedating Medications</u> A document was submitted listing those individuals sedated for dental appointments from 3/31/10 to 12/22/10. It listed 111 individuals as requiring sedation. For a population of 283 individuals, this represented a 39% sedation rate. A different roster entitled "CCSSLC Individuals that required dental sedation in 2009-10," listed 149	

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		individuals that required sedation. This represented a 53% sedation rate. This is baseline information for which to measure improvement and progress of desensitization. Documentation of the sedation was provided in the integrated progress notes, in which the medication, dosage administered, and a description of the effect were listed. There also was a Dental Log, the Sedation Usage Report, in which the individual was listed with the date of administration, the name of the medication, the dosage, the sedation timing (e.g., prior to the appointment), and a brief entry about effectiveness. The Pharmacy should maintain a similar list, and make recommendations as appropriate. Documentation was submitted related to a sample of those individuals who were administered sedation. The following provides a summary of the review of this documentation: ▪ Individual #240 received Ativan 2 mg and Atarax 50 mg on 11/19/10. Vital signs were taken prior to the dental visit every 15 minutes. A dental note was written in the integrated progress notes providing information, such as nothing by mouth (NPO) status, date of most recent consent, procedure accomplished, and timeliness of individual's arrival. ▪ Individual #124 had Atarax 100 mg on 11/29/10. Vital signs were recorded every 15 minutes prior to the dental visit. A dental visit note was recorded in the integrated progress notes, including NPO status, date of most recent consent, procedure, and timeliness of arrival. ▪ Individual #176 received Ativan 0.5 mg on 11/4/10. Vital signs were recorded every 15 minutes prior to the dental visit. A dental note was written in the integrated progress notes, including NPO status, date of most current consent, and procedure completed. ▪ Individual #363 was given Atarax 200 mg on 11/30/10. Vital signs were recorded every 15 minutes prior to the dental visit. An annual exam was completed and a dental note was written in the integrated progress notes. ▪ Individual #366 was given Ativan 2 mg on 11/8/10. Vital signs were recorded every 15 minutes prior to the dental visit. A dental note was written in the integrated progress notes including NPO status, date of most recent consent, and procedure completed. ▪ Individual #348 was given Ativan 3 mg on 11/19/10. Atarax 100 mg also was ordered, but according to the dental note, the nurse discontinued it, but did not record a reason. Vital signs were recorded every 15 minutes prior to the dental visit. A dental note was written in the integrated progress notes, including date of most recent consent. ▪ Individual #136 was given Ativan 2 mg and Atarax 200 mg on 12/1/10. Vital signs were recorded every 15 minutes prior to the dental visit. A dental note	

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		was written in the integrated progress notes, including the date of the most recent consent, and procedure completed. ▪ Individual #22 received Ativan 2 mg and Atarax 50 mg on 11/15/10. Vital signs were recorded every 15 minutes prior to the dental visit. A dental note was written in the integrated progress notes including NPO status, date of most recent consent [stated was 2/3/11], and procedure completed. Additionally, in each dental note, the effectiveness of the sedation was recorded, as well as the number of people that assisted, providing a measure of the individuals' level of cooperation. A monthly restraint tracking log for August through December 2010 was submitted. The restraint type was not defined, but appeared to be either a physical or mechanical restraint. A separate communication indicated that the Dental Department had not used mechanical restraints in the prior six months, which indicated these restraints were physical restraints. For these types of restraints, the Dental Department used 11 restraints in August, eight restraints in September, four restraints in October, 11 restraints in November, and four restraints in December. The list of those referred for dental desensitization did not include those individuals needing physical restraints. The length of time between restraint initiation and release was not recorded. The Dental Department should review these lists, and together with individuals' PSTs, consider referring these individuals for the development of desensitization plans or other strategies specifically designed to reduce the use of physical restraint. A list was submitted of those individuals who underwent general anesthesia/conscious sedation for the six months prior to the Monitoring Team's visit. Thirty-three individuals had 35 visits requiring TIVA. With desensitization, this number might be able to be reduced over time. <u>Development of Dental Policies and Procedures</u> During the past six months, the State and the Facility had worked on a number of dental policies. The DADS Policy #015: Dental Services was dated 8/17/10. A number of Facility policies for dental services were approved and implemented. These included: ▪ Q.1: Parenteral Sedation Intravenous (IV) (TIVA or MAC [Monitored Anesthesia Care]) Anesthesia, approved 11/8/10, implementation 12/8/10; ▪ Q.2: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Criteria for Use, approved 11/8/10, implementation 12/8/10; ▪ Q.3: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Medical Clearance, approved 11/8/10, implementation 12/8/10; ▪ Q.4: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Dentist Anesthesiologist, approved 11/8/10, implementation 12/8/10;	

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		▪ Q.5: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Surgery, approved 11/8/10, implementation 12/5/10; ▪ Q.6: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia - Anesthesiology Personnel, approved 11/8/10, implementation 12/8/10; ▪ Q.7: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Pre-operative Sedation prior to TIVA or MAC Sedation, approved 11/8/10, implementation 12/8/10; ▪ Q.8: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Recovery, approved 11/8/10, implementation 12/8/10; ▪ Q.9: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – REACT [Respiration, Energy, Alertness, Circulation, and Temperature] Scoring System, Vital Signs Flow Sheet, implementation 12/8/10; ▪ Q.10: Missed or Refused Dental Appointments – Criteria for Use, approved 11/8/10, implementation 12/8/10; ▪ Q.11: Monitoring of Pre-Post Dental Sedation – Criteria for Use, approved 11/8/10, implementation 12/8/10; and ▪ Q.12: Consultations – Dental, approved 11/8/10, implementation 12/8/10. Facility Policies (Dental Services) pending approval included: “Assurance,” “Standard of Care,” ”Initial Dental Examination,” “Annual Dental Examination,” “Direct Care Professional Training,” “Desensitization,” and “Chemical Intervention Protocol Working Draft.”	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should continue to implement and expand its competency-based training program for the direct support professionals concerning tooth brushing. Such training should continue to emphasize staff’s role in assisting and monitoring proper tooth brushing during times when the dental hygienist is not in the residence, in order to enhance continuity in the implementation of these important preventive activities.
2. Database entries should be reviewed continuously to ensure discrepancies do not occur in the data.
3. Emergencies should be dealt with promptly. If there is an inability to accommodate the need for an emergency visit, there should be a place to document the reasons for any delay in emergency care.
4. Pain management should be documented as part of the emergency visit exam and treatment. Identified pain should be tracked in the dental record until resolved.
5. If a follow-up appointment is requested for an acute care problem, there should be a note indicating it occurred or an entry that the follow-up did not occur with the reason.
6. Dental progress notes should have a periodic QI review to ensure the records for emergency visits are completed, notes are in chronological order, and contents of the notes address closure to the emergency.
7. Now that the Residences are responsible for reviewing daily data about missed appointments, the Residences should create a feedback system to ensure the Dental Department is made aware of progress, or obstacles, in reducing the recurrence of refusals by specific individuals. This would allow the Dental Department to prioritize which individuals' teams needed their assistance at PSTs to discuss options and

implementation action steps.

8. For “no shows” with no response, an email or written note should be sent to the QMRP requesting a written response for the missed appointment.
9. Rescheduled appointments should generally be completed within a two-month timeframe.
10. The Dental Department should meet with the PSTs to consider options to improve show rate compliance.
11. Missed appointments should be subcategorized as to the type of appointment missed and this information should be entered into the database.
12. Aggregate missed appointment data should be shared with the Unit Directors, and, as appropriate, action plans developed to address trends identified.
13. When there is a delay in medical clearance, the reason should be determined and recorded.
14. The Dental Department should refer individuals, needing physical restraints, for consideration of the development and implementation of desensitization plans and/or other strategies to reduce the need for restraint.
15. The Dental Department should be part of the interdisciplinary team that develops dental desensitization programs or other strategies to reduce refusals and/or minimize the need for chemical sedation.
16. The pharmacy department should maintain a list of pre-treatment sedation use based on their internal information, and should be a resource for alternatives in medication administration.
17. With regard to its self-assessment efforts, the Facility should continue to expand its monitoring and data review efforts to include the additional components necessary to substantiate the provision of adequate dental care (e.g., emergency care, restorative care, etc.), as well as review the quality of the dental services being provided and the outcomes being achieved for individuals (e.g., improved oral hygiene index scores).

The following are offered as additional suggestions to the State and Facility:

1. The statewide dental peer group is encouraged to arrive at a consensus on the oral index scoring system all SSLCs will use.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section R; o The following documents were requested: SLP Assessment, SLP Progress notes, SLP communication program, communication device instructions, PSP and PSP Addendums, Behavior Support Plan, SLP consultations for the last year, SLP documentation for the last year, and communication dictionary for the following 12 individuals: Individual #297, Individual #251, Individual #302, Individual #69, Individual #154, Individual #2, Individual # 16, Individual #201, Individual #117, Individual #145, Individual #131, and Individual #280; o Communication Dictionary and PNMP for Individual #170 and Individual #285; o New Policies and Procedures related to Speech and/or Communication Services and Supports, 9/10 through 11/10; o List of Individuals with AAC Devices and corresponding Habilitation Therapies Database, 2/10 through 11/10; o Alternative or Augmentative (AAC) Screening Forms (blank), undated; o AAC Evaluation and Speech Language Assessment template (blank), undated; o Five most current AAC and SLP Assessments conducted by each therapist and corresponding PSPs, 9/09 through 10/10; o Monitoring Tools template for AAC and SLP programs, undated; o Completed Monitoring Form (Communication), between 10/21/10 and 11/4/10; o OT/PT Summary Reports, Monitoring Forms, and Plan of Improvement from 5/10 through 10/10; o Communication Dictionaries for Multiple Individuals, 10/10 and 11/10; o AAC-related Spreadsheets, 3/10 through 9/10; o List of Individuals receiving Direct Speech Services and Focus of Intervention, dated 11/18/10; ▪ **Interviews with**: o Dr. Angela Roberts, AU.D., CCC-A, F-AAA; Habilitation Therapies Director and Audiologist; o Noela Morales, MS, CCC-SLP; o Linda Merryman-Scifres, BS, SLP; and o Maurie Hazlewood, MS, CCC-SLP. ▪ **Observations of**: o Individual #154; o Individual #251; and o Individual #297.
	Facility Self-Assessment: The Plan of Improvement for Section R documented noncompliance for all indicators. In the Comments/Status column, chronological updates for R.1 through R.4. identified what had been accomplished to date. An additional POI form provided the following data fields for action plans

	related to Section R.2 and Section R.4: ▪ Compliance Visit/Section and Recommendation; ▪ Outcome; ▪ Action Step; ▪ Evidence; ▪ Responsible person; ▪ Start date; ▪ Target date; and ▪ Completion Status. The Facility's findings of non-compliance for all indicators in Section R were consistent with the findings of the Monitoring Team. POI Monitoring Forms were submitted for Section R from May 2010 to September 2010. Occupational Therapist(s), Physical Therapist(s), Physical Therapy Assistant(s), and Certified Occupational Therapy Assistant(s) and a Program Compliance Monitor completed a monitoring tool for the same individual. Speech Language Pathologists did not complete a POI monitoring form during this time period. The PCM then compared the Therapist's answer to the PCM's answer for each question of the monitoring tool. If the therapist and the PCM's answers were the same, a score of 100% was documented showing 100% agreement. If the therapist and the PCM's answers were not the same a score of 0% was documented. Inter-rater reliability scores were not calculated for the POI Monitoring forms submitted from May to September 2010. The POI Monitoring Tools for Section R were completed by a Speech Therapist and the PCM in October 2010. The POI Monitoring Tools for Section R for October 2010 documented a percentage indicating inter-rater reliability between the therapist and the PCM for each indicator on the review tool. An overall inter-rater reliability for the entire tool also was provided, along with an explanation of how many tools were completed. In addition, the issue of whether the therapist and PCM agreed that the Facility was in compliance with each question was indicated in the second column. An "S" for substantial compliance indicated this. The issue of disagreement between the therapist and PCM for the Facility's compliance was indicated in the third column. An "S" indicated the therapist did not score the Facility in compliance, however, the PCM did. Ten out of 20 answers documented agreement between the SLP and the PCM. An inter-rater reliability score of 50% was achieved for October POI Monitoring for Section R. The Plan of Correction stated instructions for monitoring tools had been completed. Therapists were to be in-serviced on instructions for monitoring tools on 11/17/10. Mitigation meetings were to be held in the beginning of December. The achievement of a defined inter-rater reliability threshold between the respective therapists and the PCM will be critical to ensure confidence with indicators that are scored compliant. The revision of indicator instructions and the provision of therapist re-training presented a sound approach to achieve inter-rater reliability.

	The Facility should continue to expand its self-assessment activities, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate the monitoring tools, particularly to separate out the different types of reviews to be completed using different methodologies and samples; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring on the review tools and their implementation; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. During the entrance conference, the CCSSLC Habilitation Therapies Director indicated that the Habilitation Therapy Department had implemented the following activities related to Section R following the last compliance review: ▪ "Communication Dictionaries [were developed], which have recently been added to several PSPs. A competency-based training has been developed to teach staff how to utilize these communication dictionaries. Additionally, a pilot home (Pacific Unit) has been identified for implementation of shared functional communication systems." ▪ "A speech tab [was added] to the HT database complete with monitoring and tracking forms. The database is continually being populated with current information. This tab includes the tracking of individuals' AAC in all aspects of the individual's life." ▪ "A master communication (speech) list has been completed which details the priority level of each individual to be assessed."
	Summary of Monitor's Assessment: CCSSLC had made progress in increasing the number of SLP positions from two to four full-time SLPs, and one contract SLP at 20 hours per week. Based on interview, the hiring of a fourth SLP will enable the future caseloads of the full-time SLPs to range between 50 and 60 individuals. Reportedly, the newly hired SLP, who had been assigned as the Core PNMT member, specialized in swallowing and dysphagia. Based on information provided, the Habilitation Therapies Department was conducting an analysis of staffing needs. The Facility is encouraged to address the results of this analysis. Continuing education for the SLPs was not sufficient to augment clinical skills in augmentative/alternative communication. Individual examples provided within Section R illustrate the impact of not having an adequate number of SLPs to address the functional communication needs of the individuals residing at CCSSLC. SLPs were completing evaluations that did not follow the components of the revised SLP Evaluation template, which resulted in individuals not being provided with supports to address their strengths, potentials, and abilities for functional communication. There were not sufficient SLP resources present during the past six months to provide direct and/or indirect speech therapy supports for individuals with an identified need. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations on a

	formal and/or informal basis within an individual's PSP, and multiple environments, is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis. The two individuals who were identified as receiving direct speech therapy were provided direct therapy in a consistent manner. The SLP evaluations did not include an analysis of findings to provide a rationale for recommendation(s). In addition, monthly documentation submitted did not justify the initiation, continuation, or discontinuation of speech therapy supports; when progress was not made, recommendations and/or objectives were not revised, and there was no analysis to determine the efficacy of the supports provided. The previous compliance report recommended the Facility consider identifying a residence to pilot the development and implementation of functional communication systems across all environments. Reportedly, the Speech Department had identified an apartment for the Pilot Program. During the on-site review, the Monitoring Team could not enter this home due to quarantine. The Monitoring Team met with the SLP and PNMP Coordinator to discuss the status of the Pilot Project, but there had been no formal outcomes developed to measure the success and/or failure of the implementation of a functional communication initiative. The tasks reportedly being implemented did not provide the foundation for the implementation of an interdisciplinary team pilot project for functional communication. The intent of this recommendation was to support an interdisciplinary team process, using a problem solving approach to develop and implement a plan, including measurable, observable outcomes. This had not occurred. CCSSLC previously utilized excel spreadsheets to track the status of Habilitation Therapy information such as assessments, adaptive/assistive equipment, etc. Per report, these spread sheets did not provide tracking and trending information that was useful. A comprehensive Habilitation Therapies Database was developed in collaboration with the CCSSLC System Analyst.

#	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	<u>The Facility provides an adequate number of speech language pathologists or other professionals (i.e., AT specialists) with specialized training or experience. Training should include augmentative and assistive communication.</u> CCSSLC had made progress in increasing the number of SLP positions from two to four full time SLPs, and one contract SLP at 20 hours per week. The following chart shows the status and caseloads of the SLPs, Speech Assistants (SAs) and Audiologist at the time of the Monitoring Team's review:	Noncompliance

SLPs and SAs	Current Caseloads
SLP #1	Supported 146 individuals and Core PNMT member
SLP #2	Supported 136 individuals and Alternate PNMT member

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>training, and monitor the implementation of programs.</td><td>
<table>
<tr><td>SLP #3 (Contract-20 hours)</td><td>Began employment on 1/2/10, and was to support full time SLPs</td></tr>
<tr><td>SLP #4</td><td>To begin orientation on 1/18/10</td></tr>
<tr><td>SLP #5</td><td>Currently recruiting</td></tr>
<tr><td>SA #1</td><td>Supported 60 individuals</td></tr>
<tr><td>SA #2</td><td>Supported 82 individuals</td></tr>
<tr><td colspan="2">Audiologist</td></tr>
<tr><td>Audiologist</td><td>Supported 283 individuals, currently recruiting, Habilitation Therapy Director was former audiologist and continued to provide these services until a full-time and/or contract audiologist was hired</td></tr>
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Recruitment of SLPs included placement of an advertisement in the local newspaper, inclusion of an online advertisement at the Texas Speech and Hearing Association website, and posting of an advertisement on several college campuses that certified therapists to work in the field. Recruitment efforts had been successful and SLPs had been hired for vacant positions with the exception of ongoing recruitment for one-full-time SLP. The hiring of two full-time SLP positions and a contract SLP should have a positive impact on the implementation of strategies to achieve compliance with Section R.
The licenses of the three full-time SLPs and one contract SLP were current for practice in the State of Texas. Reportedly, the hiring of a fourth SLP would enable the future caseloads of the full-time SLPs to range between 50 and 60 individuals. A review of the CVs/resumes of one of the SLPs documented five years of experience within the field. Based on interview, the newly hired SLP, who had been assigned as the Core PNMT member, specialized in swallowing and dysphagia, but her resume was not submitted. The contract SLP had 30 years of experience in the public school system, but her CV/resume was not submitted for review.
The current caseloads of the SLPs did not enable active participation on PSTs for the individuals on their caseloads, as evidenced by their absence at annual PSP meetings; insufficient time to provide direct therapy; lack of completion of comprehensive SLP Evaluation(s) per established guidelines; insufficient development and integration of therapy recommendations into formal skill acquisition programs to support functional communication across multiple environments; lack of development of instructional programs for Speech Assistants, PNMP Coordinators and/or staff; and the inadequate development of informal strategies to reinforce SLP assessment recommendations.
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		The document entitled, Staff to Individual Ratio, dated 11/30/10, indicated the ratio for SLPs was 1:141.5, but this ratio would need to be readjusted with the recent hiring of two additional full-time SLPs and a part-time contracted SLP. The psychology staff-to-individual ratio required by the Settlement Agreement was 1:30. SLPs had similar duties with regard to assessment, planning, monitoring, and provision of direct supports and/or oversight. The Habilitation Therapies Director and staff had begun the process of analyzing the current staffing needs of SLPs through the identification of required work tasks and the correspondent time needed to complete these tasks. This was a positive initiative and should lead to the development of a realistic caseload for speech language pathologists to support compliance with the SA. Although related to schools, the following statement from American Speech and Hearing Association (ASHA) recommended that SLP caseloads not exceed 40 individuals to enable SLPs to provider appropriate services: "...in order to provide balance between the amount of time available for appropriate services and the amount of time needed to complete other required responsibilities, it is recommended that the maximum caseload size should not exceed 40 students, regardless of the type or number of service delivery models selected. Special populations and circumstances will dictate even fewer students on the caseload, since certain types of services and students are more time-intensive than others." (From ASHA's "Guidelines for Caseload Size and Speech-Language Service Delivery in the Schools") Based on interview, analysis of caseloads for SLPs was projected to be completed by July 2011. Facility Administration should provide support to the Habilitation Therapies Department to address the findings of the analysis. As appropriate, the realignment of positions should be considered to support reasonable SLP staff-to-individuals caseloads based on information gained from the analysis. Two speech language pathologists were registered for the Beckman Oral Motor Assessment and Intervention Protocol workshop scheduled for January 13 to 14, 2011 in Corpus Christi. In addition, the following chart documents SLP and SA attendance for continuing education courses:	

Continuing Education	SLP and SA	Audiologist
Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management (6/16/10)	1 SLP	
Issues in Nutritional Management (7/7/10)	1 SLP and 1 SA	

#	Provision	Assessment of Status	Compliance

PNMT Identification of Risk and Development of Interventions (7/30/10)	1 SLP	
Issues in Nutritional Management Part 2 (8/13/10)	1 SLP	
PNMT and Woundcare Investigation (8/13/10)	1 SLP	
PNMT GI Webinar for OTs (8/17/10)		
Seating and Positioning for Dysphagia (9/1/10)	2 SLPs	
Ethics for SLPs and SLPAs	1 SLP	
Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (9/20 through 22/10)	2 SLPs and 1 SA	1 Audiologist
Speech and Hearing Round Table Discussion (9/22/10)		
Competency-Based Training (10/27/10)	1 SLP	
20th Annual Habilitation Therapies Conference (9/20/10 to 9/21/10)		
Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (9/20/10 to 9/22/10)	1 SLP	
Texas Autism Conference (10/6/10 to 10/9/10)	2 SLPs and 1 SA	
Speech Language Pathology Jurisprudence Exam	1 SLP	
DADS Contract Administration Handbook Training on Administrative and Competitive Procurements		1 Audiologist

A Speech and Hearing Round Table Discussion: Communication Issues for Individuals with Developmental Disabilities in a Residential Setting occurred during the Habilitation Therapies Conference 2011. The program objectives were:

- Identify appropriate evaluation, interventions, and documentation for individuals with developmental disabilities; and
- Identify programming issues associated with augmentative communication devices and sign language use.

No documentation was submitted to verify the CCSSLC SLPs' attendance at the Habilitation Therapies Conference and/or the Speech and Hearing Round Table Discussion.

Continuing education for the SLPs was not sufficient to augment clinical skills in augmentative and alternative communication.

Communicative Aiders and Speech Generated Devices (simple and complex) are provided to individuals based on need and not staff availability. All individuals in need of AAC, receive AAC. SLPs actively participate in all facets of care in which communication is relevant.

#	Provision	Assessment of Status	Compliance
		Twelve individual's records were reviewed, including: Individual #297, Individual #251, Individual #302, Individual #69, Individual #154, Individual #2, Individual #16, Individual #201, Individual #117, Individual #145, Individual #131, and Individual #280. Two of the 12 records reviewed (Individual #297 and Individual #251) (17%) indicated they were receiving active speech treatment and/or participating in a speech program. An additional three individuals had been identified to receive direct speech services per a document dated 11/18/10, including Individual #302, Individual #69, and Individual #154. None of the two individuals' records reviewed (0%) (Individual #297 and Individual #251) were provided direct therapy in a consistent manner. The SLP evaluations did not include an analysis of findings to provide a rationale for recommendation(s). In addition, monthly documentation submitted did not justify the initiation, continuation, or discontinuation of speech therapy supports; when progress was not made, recommendations and/or objectives were not revised; and there was no analysis to determine the efficacy of the supports provided. The following issues were noted: ▪ Individual #297's Speech Language Evaluation, dated 11/22/10 to 12/2/10, and a Speech Language Update and Annual Summary, dated 1/28/10 to 1/29/10, included 11 recommendations. The following recommendation referred to receiving speech therapy: "[Individual #297] should continue in Speech Therapy to learn core vocabulary and customized messages on her Vantage Plus in order to become a functional communicator. There are times that [Individual #297] wants to say something but cannot express it. Once staff finds out what the word or message is, it should be written in [Individual 297's] message folder that is kept in her back pack. This applies to ALL staff." This recommendation was not supported by a measurable, functional outcome, nor did speech progress notes document the efficacy of the speech therapy that she had received since June 2008, which should have resulted in program changes to address her lack of progress. The evaluation indicated Individual #297 had been enrolled in speech therapy since June 2008, with the "focus on using Core Vocabulary on the Vantage Plus to create functional messages with 80% accuracy. She had continued in Speech Therapy since that time with sporadic progress noted due to refusing to attend therapy, illnesses and problems with the communication device." A review of Speech Therapy Progress Reports since the last compliance review documented that Individual #297 did not receive consistent, ongoing therapy. More specifically: o She attended only two therapy sessions in July, on the 12th and 13th; o Communication device was not working on July 15th, and it was sent out for repair; o Communication device was received on August 20th, o Attended one therapy session in August, on the 26th;	

#	Provision	Assessment of Status	Compliance
		o Attended one therapy session for 30 minutes during the month of September; o No documented therapy sessions for October; o No documented therapy sessions for November; and o Documented one therapy session for December. The submitted Speech Therapy Progress Reports did not support that Individual #297 was consistently receiving direct therapy supports. ▪ Individual #251 did not have a SLP Comprehensive Assessment completed to provide the rationale and justification for receiving direct therapy services. An Annual Summary, dated 10/15/10, recommended: "[Individual #251] will continue to work in speech therapy to become functional on her electronic device." According to documentation submitted, Individual #251 did not have a therapy communication program. Her therapy objective stated: "By 07-01-11, [Individuals #251] will independently produce 50 functional messages using Conversa electronic communication aid, within the therapy sessions with 80% accuracy." Monthly progress notes completed by a speech assistant and/or a SLP did not document her progress with this identified goal. For example, the progress note for 7/1/10 to 7/31/10 acknowledged that Individual #251 was "getting acquainted with her new electronic system." The progress note did not document the number of sessions completed during the month of July, and did not present data to document her progress, and/or lack of progress, related to her objective. None of the 10 records reviewed (Individual #302, Individual #69, Individual #154, Individual #2, Individual #16, Individual #201, Individual #117, Individual #145, Individual #131, and Individual #280) (0%) indicated individuals with identified language difficulties were receiving direct and/or indirect speech services. Examples of individuals with identified speech or language difficulties not receiving speech services included: ▪ The Monitoring Team observed Individual #2 trying to communicate with Team members and her staff. However, no functional communication supports were available to assist her, the Monitoring Team, and/or the staff. The Speech and Language Update, dated 6/25/10, documented that she had "a picture communication system to use when her level of alertness and processing declines secondary to her blood sugar fluctuation. With current environment and staff support, her communication skills are adequate and appropriate." The Monitoring Team strongly disagrees with this statement. An observation of Individual #2 documented her frustration with not being to communicate her needs and be understood by the Monitoring Team and staff. ▪ Individual #302's Speech Language Update, dated 8/14/10, stated: "Speech therapy is recommended for [Individual #302] to more aggressively teach him	

#	Provision	Assessment of Status	Compliance
		to use his voice-output communication aid effectively." No direct therapy had been provided. This was evidenced by the fact that he did not have a formal SLP communication program and no progress notes for the past year. ▪ Individual #69's Speech and Language Update, dated 7/17/10, recommendation stated: "A voice-output communication aid will be investigated to determine if [Individual #69] will use and derive benefit from it." It was unclear why his SLP evaluation did not provide a comprehensive assessment of this augmentative/alternative communication device. ▪ Individual #16's Speech and Language Update, dated 3/2/10, documented "no formal speech therapy is recommended at this time," but further stated "caregivers should encourage the use of [Individual #16's] AAC device with ADL's." Individual #16 needed a SLP to provide support, to him and his staff, to develop intervention strategies for integration into skill acquisition programs, to support the facilitation of functional communication. ▪ Individual #201's Speech and Language Update, dated 1/6/10, documented "[Individual 201] does not utilize AAC." He had not received a comprehensive augmentative/alternative communication to identify his strengths, potentials, and abilities for functional communication. ▪ Individual #117's Habilitation Therapies: Speech and Language Statement, dated 12/23/10, stated "Although this PSP was scheduled, due to formatting of the Master Speech Plan, communication skills will be addressed within 3 years. Please refer to last year's update and notify the Speech Department of a life changing event or if a regression in communication occurs."	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	All individuals in need of AAC are identified as being in need of AAC. None of the 12 records reviewed (0%) indicated that individuals identified with severe expressive/receptive language had AAC investigated, assessed, and if identified as being in need of AAC, were provided ongoing support by an SLP to support the facilitation of functional communication. Examples of concerns are provided with regard to Section R.1 of the Settlement Agreement. Documentation provided indicated that prior to October 2010, Speech Re-Evaluations and Speech Updates were being performed according to the PSP Monthly Calendar. To integrate services with psychology and provide augmentative/alternative communication assessments according to priority needs, speech therapists had begun the process of developing a Master Speech Plan that was prioritized as follows: ▪ Priority 1 o Individuals with a Behavior Support Plan (BSP) and/or Autism who do not speak; and o Individuals who have experienced a Life Changing Event that has affected communication skills and/or ability to eat or swallow.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Priority 2 o Individuals with a BSP and/or autism who speak. ▪ Priority 3 o Individuals without a BSP and/or Autism who do not speak. ▪ Priority 4 o Individuals without a BSP and/or Autism who speak. Three draft Master Plan(s) for Speech Assessment identified the following breakdowns of numbers of individuals according to the priority levels: **Draft 1 for 276 individuals (dated 12/4/10)** ▪ 50 individuals designated as Priority 1; ▪ 99 individuals designated as Priority 2; ▪ 117 individuals designated as Priority 3; and ▪ 10 individuals designated as Priority 4. **Draft 2 for 283 individuals (dated 12/14/10)** • 56 individuals designated as Priority 1; • 99 individuals designated as Priority 2; • 118 individuals designated as Priority 3; and • 10 individuals designated as Priority 4. **Draft 3 for 282 individuals (undated)** • 55 individuals designated as Priority 1; • 99 individuals designated as Priority 2; • 118 individuals designated as Priority 3; and • 10 individuals designated as Priority 4. The following fields were on the Master Plan: admission number, last name, first name, middle initial, priority, last evaluation [date], current evaluation, and proposed evaluation date. The proposed evaluation date was blank for Draft 1 and 2. Draft 3 identified proposed individual evaluation completion dates for Priority 1 individuals by 7/15/11, Priority 2 individuals by 7/6/12, Priority 3 individuals by 8/30/13, and Priority 4 individuals by 10/11/13. Habilitation Therapies should re-evaluate the timelines included in the third draft of the Master Plan for Speech Assessment, which exceeded the Settlement Agreement requirement that full implementation be completed with three years of the Settlement Agreement Effective Date. As the Master Speech Plan was being finalized, the following statement was provided to the QMRPs prior to individuals' PSP meetings, and was found in many of the PSP assessment packages that the Monitoring Team reviewed: "Although this PSP was scheduled due to formatting of the Master Speech Plan, communication skills will be addressed within 3 years. Please refer to last year's update and the additional	

#	Provision	Assessment of Status	Compliance
		recommendations listed below. Notify the Speech Department if a life changing event or if a regressions in communication occurs." The portion of the statement about which the Monitoring Team was concerned read: "communication skills will be addressed within 3 years." The statement provided to the PSTs should have identified an individualized timeframe related to the individual's priority level as defined on the Master Speech Plan. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> There were no admissions to CCSSLC since the baseline review. A CCSSLC Habilitation Therapies: Speech and Language Screening form, undated, was submitted. This form was in a checklist format for the following areas: ▪ Receptive language; ▪ Hearing; ▪ Vision; ▪ Oral motor; ▪ Expressive language; ▪ Pragmatic skills; ▪ Augmentative/alternative communication; ▪ Environmental control unit; and ▪ Communication Dictionary Information for unaided AAC users. There were no protocols/policy provided to describe how this screening form was to be utilized. An AAC Evaluation Tool "was created by the SLP and has been discussed for implementation at PNMP clinics. It was developed with an Integrative Team Approach in mind as each PST member provides valuable input and information in regards to the residents." The tool, primarily in a checklist format, addressed the following: ▪ Name, case number, date of birth, address and date; ▪ Provided definition of unaided AAC; ▪ Provided definition of aided AAC; ▪ Has cognitive ability to use aided AAC; ▪ Has interest/motivation in using aided AAC; ▪ Uses aided AAC such as adaptations, tactile system, communication board/poster, communication book, and electronic communication device; ▪ Identify type of AAC device used (direct select and/or scanning); ▪ Use of Environmental control unit for method of access, level of prompt, type of switch; ▪ Communication dictionary for unaided AAC to describe/explain how individual communicates;	

#	Provision	Assessment of Status	Compliance
		▪ Additional comments; and ▪ Formal report to follow. It was positive that the Speech Department was addressing the need for augmentative/alternative communication devices to be reviewed during PNMP Clinics. However, no policies/procedures had been developed to describe how this tool would be utilized during the PNMP Clinic. The Facility's Speech Department Comprehensive Evaluation Format, dated 12/10, included the following: ▪ Statistical Information; ▪ Diagnosis and Pertinent History to include pertinent medical procedures, surgeries, and medical conditions that could influence testing results or recommendations, including specialized evaluations, previous testing, and sensory impairments; ▪ Medication/Precautions to include list of medications and precautions that are safety related and physical, medical or functional limitations; ▪ Sensory Impairment; ▪ Behavioral Considerations; ▪ Communication History: o Method of communication; o Previous evaluations and treatment; and o Reports from significant others; ▪ Receptive Language Skills: o Response to assessments; o Response to directions/commands; o Response to questions; and o Identification of objects/pictures; ▪ Expressive Language Skills: o Response to assessment; ▪ Pragmatic/Social Communication; ▪ Articulation: o Response to assessment; and o Oral mechanism; ▪ Voice and Fluency: o Voice quality and resonance; and o Fluency; ▪ Augmentative/Alternative Communication: o Communication book/folder, communication board, communication poster, sign language, tactile signs, electronic augmentative device, other, and attention seeking device; and	

#	Provision	Assessment of Status	Compliance
		○ Development of an augmentative/alternative means of communication; ▪ Environmental Control Assessment; ▪ Writing and Literacy Skills; ▪ Barriers to Communication; ▪ Clinical Impressions: ○ Summary of findings/interpretation of results; and ○ Strengths and needs; and ▪ Recommendations. None of the 12 Individual records reviewed (Individual #297, Individual #251, Individual #302, Individual #69, Individual #154, Individual #2, Individual # 16, Individual #201, Individual #117, Individual #145, Individual #131, and Individual #280) incorporated the HT Speech Department Comprehensive Evaluation Format. Consideration should be given to providing additional guidelines to supplement the format to ensure a consistent approach by SLPs during the evaluation process. The development of audit protocols would support SLP Evaluations following established guidelines as outlined in the SLP evaluation format. In addition, the development of procedures to define the SLP update process, to be followed when an individual experienced a change in status, would be beneficial. <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> In none of the two records reviewed (0%) for individuals reported to be receiving direct speech therapy services, were goals/objectives developed related to language acquisition or functional communication, nor had the SLP written measurable goals/objectives, and outcomes. These were not followed on a monthly basis if service was direct, and quarterly if indirect. Examples of individuals diagnosed with severe language difficulties, where AAC was assessed or investigated, but SLP supports were not recommended to provide direct guidance to the PST to integrate an AAC device across all natural environments for the individual, were provided above with regard to Section R.1 of the Settlement Agreement. Individual examples provided regarding Section R illustrated the impact of not having an adequate number of SLPs to address the functional communication needs of the individuals residing at CCSSLC. SLPs were completing evaluations that did not follow the components of the revised SLP Evaluation template, which resulted in individuals not being provided with supports to address their strengths, potentials, and abilities for functional communication. There were not sufficient SLP resources present during the past six months to provide direct and/or indirect speech therapy supports for	

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		individuals with an identified need. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations, on a formal and/or informal basis, within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis. For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP. Based on documentation provided, "the Speech Therapists met with the Psychologists to introduce the Priority Levels of Augmentative/Alternative Communication Assessment and Collaboration for Individuals with Positive Behavioral Support Plans (PBSP) in October 2010. We also discussed Communication Dictionaries. We have been consulting with individual Psychologists via phone calls, face to face meetings and/or email concerning certain residents with PBSP, integration of Speech services and Communication Dictionaries. The will be an ongoing process as we work together to support the PBSP of individuals" (Presentation Book for Section R, December 2010). A document entitled Procedures for Collaboration between Psychology and Speech, dated 11/1/10, identified six procedures to be followed in the development of Communicating Dictionaries: ▪ Communication Dictionary (CD) to be developed by a Speech Assistant after gathering information from identified resources. The SLP would review the CD and make changes, if necessary. ▪ CD would be forwarded to the individual's psychologist for review, revisions, and/or additions, if needed. ▪ SLP and psychologist would collaborate to integrate appropriate behavior management techniques in the CD, if appropriate. ▪ As the psychologist developed the PBSP, contact would be made with the SLP to collaborate on revisions to the CD, if needed. ▪ When CD was completed, it would be forwarded to the PST to be presented at the PSP meeting. ▪ Staff would receive an in-service on the CD. The CD would be placed in Personal Support Book behind the PNMP. The original CD would be filed in the Active Record. These procedures primarily focused on collaboration between the speech language pathologist and psychologist, but did not provide specific guidelines to the speech assistant for the development of a CD.	

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		The Plan of Improvement stated: "Communication dictionaries were developed. They have recently been added to several PSPs. A competency-based training has been developed to teach staff how to utilize communication dictionaries (which are portable across settings). Communication dictionaries are being made on rotation with the staffing calendar as individuals are identified with a need. To date we have issued approximately 40 communication dictionaries. It is not possible at this time to determine a percentage of completion as not all individuals need one. We are in the process of identifying how may individuals require a CD, then we will be able to extrapolate an accurate percentage of completion." None of the seven records reviewed of individuals with BSPs (Individual #69, Individual #2, Individual #117, Individual #251, Individual #297, Individual #145, and Individual #280) (0%) documented collaboration with the psychologist and SLP in the development of the Behavior Support Plans (BSP). <u>Policy exists that outlines assessment schedule and staff responsibilities.</u> Per the document request for X.V.1. "Local Speech policies need to be developed. We are in the process of working on different speech procedures and work with various disciplines on a daily basis to integrate services." The Monitoring Team will review speech step-down policies and procedures during the next on-site compliance review.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	The use of AAC devices have the ability to change the way an individual is able to communicate their needs in the classroom, home, work and leisure environments for individuals with intellectual disabilities through increasing participation, making choices, and enhancing functional communication skills. Most importantly, when an individual has learned how to use an AAC device to communicate successfully, the perceptions and stereotypes of a familiar and/or unfamiliar communication partner change, from not believing the individual would be able to communicate, to exploring multiple strategies to communicate with an individual. Speech language pathologists must provide sufficient competency-based training and instructional support to staff, to give them the foundational skills necessary to support individuals in the utilization and implementation of individual-specific and generic functional communication devices in multiple natural environments. <u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.</u> None of the 12 records reviewed (Individual #297, Individual #251, Individual #302, Individual #69, Individual #154, Individual #2, Individual #16, Individual #201, Individual #117, Individual #145, Individual #131, and Individual #280) (0%) had a	Noncompliance

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		clear rationale and description of communication interventions integrated into the PSP. Examples are provided with regard to Sections R.1 and R.2 in which communication strategies were listed in individuals' PSPs, but these strategies were not integrated into action plans and/or skill acquisition programs. As stated above, for an individual to succeed in learning how to communicate effectively and give themselves a voice with an AAC device, there must be multiple learning opportunities, formal and informal, across all environments (residence, work, leisure, and community inclusion opportunities). There were no procedures to incorporate the CD into an individual's PNMP. The following examples document incongruence between an individual's PNMP and a CD: ▪ A CD developed for Individual #170, dated 11/8/10, stated: "[Individual #170 communicates by using his body language, natural gestures, facial expressions and vocalizations. Talk to him about everything he sees, hears, touches and does throughout his day (parallel talk). Provide opportunities throughout his day to make choices in clothes, food activities, etc." His PNMP, dated 11/8/10, did not discuss the use of his CD. ▪ Individual #297's CD had not been incorporated into her PNMP, because there was no addendum to address the implementation of her CD. ▪ Individual #285's CD, dated 1/5/11, had not been identified in his PNMP. His most current PNMP was revised on 10/20/10. <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> None of the 12 records reviewed (0%), in which communication interventions were referenced in the assessment section of the PSP, had evidence of integration of the individual's methods for functional communication, as well as strategies for use by staff, integrated throughout the PSP. Such programs generally were just listed or referenced, but not integrated into other programs, including, but not limited to, the individual's BSP, day program, skills training in the residence, leisure activity programs, work environments, and informal activities within their daily schedule. <u>AAC devices are portable and functional in a variety of settings.</u> None of the 12 PNMPs reviewed (0%) reinforced the use of AAC devices that were portable and functional in a variety of settings (i.e., mealtime, work, leisure, residence, community outings). <u>AAC devices are individualized and meaningful to the individual.</u> None of the two records reviewed (Individual #297 and Individual #251) (0%), for	

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		individuals receiving direct speech services, clearly indicated how the direct speech language services would be individualized and/or encouraged the use of speech generating devices, beyond the direct speech services sessions, to ensure these devices were meaningful and functional for the individual. None of the two records reviewed (Individual #297 and Individual #251) (0%), had formal communication programs developed, with individualized strategies to be implemented by staff to reinforce what was being learned in direct speech therapy related to the individual's AAC device. The absence of formal integration of the AAC communication device in their daily schedules did not support the AAC devices being functional and meaningful to the individual and provide multiple opportunities to practice the use of their AAC device. Staff are trained in the use of the AAC. Based on a review of 12 individuals' records (Individual #297, Individual #251, Individual #302, Individual #69, Individual #154, Individual #2, Individual #16, Individual #201, Individual #117, Individual #145, Individual #131, and Individual #280), one (8%) included competency-based staff training documentation. Staff must be able to demonstrate their competency in understanding and operating an AAC system (low tech and high tech), as well as understand how to engage/prompt an individual with the AAC device in multiple environments, and competency-based training should require staff to demonstrate both of these sets of skills. The previous Monitoring Team report recommended the following: "The Facility should consider identifying a home to pilot the development and implementation of functional communication systems across all environments. This would promote interdisciplinary planning, development and implementation of an environment that supports and encourages functional communication throughout the 24-hour day." According to staff, the Speech Department had identified the Pacific Unit: Apartment 524A for the Pilot Program designed to integrate AAC across all environments (Habilitation Therapies: Speech Department, Pilot Program for Integration of AAC, December 2010). During the on-site review, the Monitoring Team could not enter this residence due to quarantine. The Monitoring Team met with the SLP and PNMP Coordinator to discuss the status of the Pilot Project, but there had been no formal outcomes developed to measure the success and/or failure of the implementation of a functional communication initiative for individuals living in Apartment 524A. The following written information was provided regarding the Pilot Program for Integration of AAC: ▪ This residence had two shared picture communication boards that were designed to be portable and could be moved for different activities and/or be presented at eye level for individuals. ▪ This home had a few voice output communication devices.	

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		▪ The Speech Department was in the process of ordering more individual voice output programmable devices. ▪ Personal environmental control units were needed for a few individuals. ▪ Instructions for use of some of the devices have been gathered and created but had not been in-serviced recently. ▪ A few devices had not been labeled with operating instructions, but the plan was to label and provide instructions for all. ▪ Competency-based training tests and a picture library of all the equipment had not been developed. ▪ Communication dictionaries had been created as Personal Functional Assessment, PNMP Clinics, and Support Plan meetings take place. ▪ Employees were in-serviced and tested on the individual Communication Dictionaries once they were created. This process will be ongoing. ▪ Speech Therapist had been consulting with the PNMP Coordinator, who was assisting with the Pilot Home Project. The PNMP Coordinator had been gathering materials for activities and assuring the working condition of the equipment. ▪ The shortage of staff and current volume of work had limited the time available to support the Pilot Project. The tasks reportedly being undertaken did not provide the foundation for the implementation of an interdisciplinary team pilot project for functional communication. The intent of this recommendation was to support an interdisciplinary team process, using a problem solving approach, to develop and implement a plan, including measurable, observable outcomes. Such a plan should have been designed to support the implementation of functional communication for individuals and staff across multiple environments, such as the residence, work, leisure activities, and experiences within the community. This had not occurred.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a	Monitoring system is in place that tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device. Reportedly, there were no step-down policies and/or protocols developed to define the communication monitoring system. However, various forms were being utilized to monitor the status of communication devices. The Communication Equipment Monitoring Form, undated, was reportedly being used. The form had the following data fields: name; address; use schedule; location; type of equipment; distribution date; date [of monitoring]; monitoring frequency; device being used?; if not, why not?; still valid?; if not, comment on effectiveness of device; next scheduled review; follow-up information; and where device is being used: home, work,	Noncompliance

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	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.	class, other. The Monitoring Team's document request asked for completed monitoring forms for the past month. No (0%) Communication Equipment Monitoring Form[s] were submitted for review. A Monthly Person-Specific PNMP Check Sheet was completed for individuals included in the sample. It contained a section to identify the type of communication device, the condition, if the device was being used, and notation of problem(s) identified. In addition, Habilitation Therapies completed a PSP Monthly Review. It had a communication section with the following information to be completed: ▪ Has current speech program? Changes? ▪ Has Augmentative Communication Device/System? If no, plan in place to assess/utilize ACD? ▪ Has environmental communication and control device available? If no, plan in place to make devices available? ▪ Details? ▪ Other Issues/concerns? None of the 12 individual records (Individual #297, Individual #251, Individual #302, Individual #69, Individual #154, Individual #2, Individual #16, Individual #201, Individual #117, Individual #145, Individual #131, and Individual #280) documented a consistent approach to monitoring communication devices. A review of an individual's PMMP, SLP Evaluation, and/or PSP Monthly Review did not support that staff had identified the current system that an individual used and/or were monitoring identified communication systems. The following individual concerns were noted: ▪ A PSP Monthly Review, for review period 9/1/10 through 9/30/10, documented: "[Individual 154] has a 'Leo' device with 32 symbols that she accessed with a head switch." The review form stated: "Both Leo and 4 message device not working" with no further discussion and/or documentation of when her communication devices would be repaired. The Monthly Person-Specific PNMP Check Sheet, dated 9/22/10, documented her "communication device" was in good condition, was being used and no problems were identified. Subsequent Monthly Person-Specific PNMP Check Sheets identified a "4 message communication device," but did not document the presence of a "Leo." In addition, her PNMP, dated 6/21/10, documented "a 4 message communication device and a wireless switch mounted on her wheelchair to express her wants and needs." It will be important to ensure that all documents (i.e., PSP, PNMP, HT Database, monitoring forms, etc.) consistently reflect an individual's communication devices. ▪ Individual #145's PNMP, dated 9/23/10, in communication stated: "[Individual	

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		#145] has a picture communication board. She also utilized the dorm communication board, a board in her bedroom and the one in the activity room when prompted." The Monthly Person-Specific PNMP Check Sheet identified a "communication board," but did not consistently address which communication board was being monitored, such as the picture communication board, dorm communication board, a board in her bedroom, and/or the one in the activity room. PSP Monthly Review, review period 9/1/10 through 9/30/10, documented under issues/concerns that a personal environmental control unit (ECU) had been requested for Individual #145's use. The form documented under recommendations: "this section should state actions to be taken by the discipline/person completing this report to address issues identified above." However, no actions were documented regarding obtaining the ECU device. ▪ Individual #131's PNMP, dated 10/26/10, acknowledged: "[Individual #131] is able to communicate through facial expressions and gestures." His PSP Monthly Review, review period 9/1/10 through 9/30/10, stated: "[Individual #131] had a single message voice output communication device attached to his wheelchair. He was not interested in using it to communicate his message 'Please don't touch my things.' The w/c was modified and the device was taken off. He also has access to various other single message devices and picture communication systems in the home and in the classroom if he chooses to use them. He requires assistance with these aides." His PNMP did not provide staff instructions for utilization of generic communication devices. No recommendations were made to address alternate communication strategies for Individual #131. ▪ Individual #280's Speech and Language Evaluation, dated 9/23/10, recommendation #4 acknowledged: "A Communication Dictionary has been created to identify unaided augmentative/alternative communication by which [Individuals #280] expresses herself. Development of the Dictionary may be an ongoing process as input from people familiar with [Individuals #280] may be added from time to time." Monthly PNMP Person-Specific PNMP Check Sheet(s) dated 10/17/10, 11/9/10, and 12/15/10, documented the communication section as N/A and did not monitor the presence of a communication dictionary. A Communication Dictionary was not submitted for review. ▪ Individual #297's PNMP, dated 2/25/09, stated in the Communication section: "Understands what is said to her, but had difficulty answering verbally. She uses a communication board, communication device, gestures, and facial expressions to communicate. Give her extra time to express her needs." The PNMP and PNMP Person-Specific Check Sheet did not identify the type of lapboard and/or electronic communication device used by Individual #297. ▪ Individual #251's PNMP, dated 11/2/10, did not address the use of her Conversa electronic communication device, nor was this device monitored on the Monthly	

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		Person-Specific PNMP Check Sheets. The monthly monitoring forms tracked an activity tray and documented: "[she] doesn't like it" under problems identified, but no resolution was identified for the problem. ▪ Individual #117's Speech and Language Update's, dated 1/11/10, acknowledged in the recommendations section: "Speech therapy is no longer recommended for [Individuals #117], as he has not appeared to benefit from it in the past. Staff should continue to encourage [Individual #117] to use his communication board to clarify messages that are not understood." His PNMP, dated 10/26/10, did not address the use of a communication board. His Monthly Person-Specific PNMP Check Sheets, dated 8/16/10 and 9/21/10, documented the communication section as "N/A." The Monthly Person-Specific PNMP Check Sheets, dated 10/26/10, documented a communication board; 12/2/10, documented a flip/up communication board, and 12/14/10, documented a flip/up communication board on his wheelchair. There was a lack of congruency between his SLP evaluation, PNMP, and/or monthly PNMP monitoring forms in accurately identifying his communication devices. ▪ Individual #302's PNMP, dated 9/23/10, stated "[Individual #302] received a 'Say It Sam' device that he uses to communicate around campus he places it on his waist like a fanny pack." There were no monthly PNMP Check Sheets completed for November and December 2010. Individual #302 had a Communication Dictionary developed on 11/29/10, but his PNMP had not been revised to reflect the presence and/or use of a communication dictionary. ▪ Individual #201's PNMP, dated 2/11/10, stated: "[Individual #201] does not use speech to communicate. He uses facial expressions and body language to communicate. Encourage use of dorm ECU's to promote cause/effect skill training." PSP Monthly Review, review period from 8/1/10 through 8/31/10, confirmed: "picture adaptations are available for choice making in the home and in the classroom." PNMP Monthly Person-Specific PNMP Check Sheets only documented "ECU" in good condition and being used, not whether the cause and effect training was occurring. ▪ Individual #16's Speech and Language Update, dated 3/2/10, confirmed: "caregivers should encourage the use of [Individual #16's] AAC device with ADL's [activities of daily living]." His PNMP, dated 11/19/10, did not identify the presence and/or use of a person-specific AAC device and communication dictionary. ▪ Individual #69's PNMP, dated 8/17/10, in the area of communication stated: "[Individual #69] can follow two part commands. He converses verbally using words and phrases. He routinely supplements verbal speech with gestures and simple sign language. He will get out his book to clarify messages, usually when requested." His Monthly Person-Specific PNMP Check Sheets, dated 8/18/10,	

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		communication section was marked "N/A," but check sheets dated 9/17/10 and 10/19/10 acknowledged a "picture book," but the condition, use and problems identified fields were blank. ▪ In Individual #2's Speech and Language Update, dated 6/25/10, recommendation number four stated: "When necessary and appropriate, prompt [Individual #2] to use her personal communication system to encourage communication and to make sure her wants and needs are met." Her PNMP, dated 7/29/10, and Monthly PNMP Monitoring Check Sheets, dated 7/26/10, 8/22/10, 9/23/10, 10/24/10, 11/15/10, and 12/19/10 did not address a personal communication system. Habilitation Therapies should complete an analysis of all current documents and monitoring forms, related to communication devices, to ensure consistency across all documents. This analysis should provide the foundation for the development of speech policies and procedures. Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home. As noted in the individual examples above, monitoring was insufficient. CCSSLC previously utilized excel spreadsheets to track the status of Habilitation Therapy information such as assessments, adaptive/assistive equipment, etc. Reportedly, these spreadsheets did not provide tracking and trending information that was useful. A comprehensive Habilitation Therapies Database was developed in collaboration with the CCSSLC System Analyst. Based on interviews with staff, the database was being populated with current information regarding what communication systems were distributed across campus. The Habilitation Therapies Speech Database had been created, but had not been finalized. Information from the former Excel spreadsheet for speech was being transferred to the Speech Data Base. Individuals with last names from A to G had been completed. The Speech tab included the following information: ▪ Speech and Language with the following sections that, if appropriate, include multiple choices to identify individual-specific information: o Initial evaluation date; o Most recent evaluation date; o Priority; o Method of communication; and o Receptive language; ▪ ECU [Environmental Control Units] with the following data fields:	

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		o Has ECU; o Method of access; and o Comments; ▪ AAC: o Unaided AAC: o Aided AAC; and o Comments; ▪ Communication Equipment Monitoring: o Monitoring staff; o System; o Date Monitoring frequency; o Device being used; o Meaningful/effective; and o Therapist responsible. Based on interview and observation, the Habilitation Therapies Database was not a static system. The System Analyst had the ability to update and revise the database to enable Habilitation Therapies to run individual-specific reports as well as system reports. Validation checks are built into the monitoring process and conducted by the plan's author. The Habilitation Therapies Database Speech tab included a way for systems to be validated by the author. Based on interviews with staff, CCSSLC had not begun the monitoring process.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Once the Habilitation Therapies Department completes its staffing analysis, Facility Administration should provide support to the Habilitation Therapies Department to address the findings of the analysis. As appropriate, the realignment of positions should be considered to support reasonable SLP staff-to-individuals caseloads based on information gained from the analysis.
2. Additional opportunities for continuing education for the SLPs in the area augmentative/alternative communication should be identified and offered.
3. Habilitation Therapies should re-evaluate the timelines, included in the third draft of the Master Plan for Speech Assessment, which exceeded the Settlement Agreement requirement that full implementation be completed with three years of the Settlement Agreement Effective Date.
4. Additional guidelines should be developed to supplement the Speech Language Evaluation format to ensure a consistent approach by SLPs during the evaluation process. In addition, the development of procedures to define the SLP update process to be followed when an individual experienced a change in status would be beneficial.
5. Audit protocols should be developed and implemented to ensure SLP Evaluations follow established guidelines as outlined in the SLP evaluation format.
6. The role and responsibilities of the Speech Assistant, in the development of the Communication Dictionary, should be better defined.

7. Individuals' communication devices and strategies should be consistently integrated into their PNMPs.
8. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as their BSPs to ensure the AAC device is meaningful to the individual and they have a voice in multiple environments.
9. Habilitation Therapies and Psychology should establish protocols to ensure collaboration and documentation of this collaboration in the development of functional communication strategies, not only for inclusion in an individual's BSP, but for total integration within an individual's PSP.
10. Habilitation Therapies should re-evaluate the pilot functional communication initiative, which should promote interdisciplinary planning in the development and implementation of an environment that supports and encourages functional communication throughout the 24-hour day.
11. Appropriate methods to test staff's competency with regard to the use of AAC devices, as well as to engage the individuals in their use, should be developed and implemented.
12. Policies/procedures should be developed for the communication monitoring system, with performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of the functional communication programs and equipment; staff utilization of generic AAC devices; fit, function, availability and use of AAC devices; and staff competency with regard to functional communication devices and programs. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book and Opening Visit Presentation Notes, Section S, completed by Bruce Boswell, Director of Day Programs/Active Treatment and Interim Acting Director of Behavioral Services; o Person Directed Planning and Active Treatment – Implementing and Documenting Active Treatment Programs Policy, draft policy, revised 11/15/10; o CCSSLC Policy - Habilitation, Training, Education, and Skill Acquisition: Implementing and Documenting Active Treatment Programs, approved 11/8/10 and implemented 12/8/10; o CCSSLC Plan of Improvement, Section S, dated 9/27/10; o Training Documentation on Skill Acquisition Plans methodology and process, including integration with Behavioral Services Staff, dated 8/18/10, 8/20/10, 8/25/10, 9/1/10, 9/2/10, 9/20/10, 9/29/10, and 11/17/10; o CCSSLC Skill Acquisition Plans Review Committee Minutes, dated 11/24/10 and 12/29/10; o Examples of completed '5 Minute Engagement Monitoring Form', dated 8/23/10, 12/7/10, and 12/15/10; o Training documentation (ITTP) on '5 Minute Engagement Monitoring', dated 12/28/10; o Plan of Action, including outcome, action step, evidence, responsible person, dates, and status, for previous recommendation Section S #1; o Onsite chart reviews of: Individual #47, Individual #246, Individual #243, Individual #255, Individual #348, Individual #51, Individual #300, Individual #42, Individual #311, Individual #307, and Individual #77; o Personal Support Plans (PSPs), Personal Focus Worksheet (PFW): Individualized Assessment Screening Tool or Personal Focus Assessment (PFA), Positive Adaptive Living Skills (PALS), Skill Acquisition Plans, PSP Monthly Reviews (since November 2010), as available, for: Individual #47, Individual #246, Individual #243, Individual #255, Individual #251, Individual #300, Individual #42, Individual #311, Individual #307, Individual #70, Individual #244, Individual #333, Individual #312, Individual #7, Individual #109, Individual 275, Individual #268, Individual #118, Individual #10, Individual #145, Individual #305, Individual #92, and Individual #297; o CCSSLC "Names and homes of 34 individuals for whom skill acquisition plans have been developed using new format"; o Individuals employed on and off campus – including number of hours worked, from 7/19/10 through 11/12/10, including the job setting; o Email to Bruce Boswell and Iva Benson regarding new vehicle assignments, dated 11/1/10; o Methods of Transportation for Outings During Reporting Period, including Individuals

	Who Utilized Public Transportation for Outings, dated 9/1/10 through 9/30/10, 10/1/10 through 10/31/10, 11/1/10 through 11/30/10, and 12/1/10 through 12/31/10; o Names and homes of 86 individuals who have skill acquisition programs for community settings, including a description of the targeting outing, not dated; o Summary of Outing and Activity Participation for the past six months; o Plan of Action S:CR.1.20 Habilitation, Training, Education, and Skill Acquisition; o CCSSLC Draft Vocational Assessment (blank rubric); o Completed CCSSLC Draft Vocational Assessment for Individual #348, Individual #300, Individual #255, Individual #42, Individual #251, and Individual #246; o Vocational Assessment Review Committee Minutes from 11/2/10, 11/8/10, 11/10/10, 11/16/10, 11/17/10, 11/22/10, 11/23/10, 11/30/10, and 12/01/10; o Training Documentation (ITTP) for Draft Vocational Assessment Training, dated 10/26/10; o CCSSLC Summary Document – Names and homes of 26 individuals for whom comprehensive draft vocational assessments have been completed, not dated; o CCSSLC Policy - Habilitation, Training, Education, and Skill Acquisition: Ensuring Community Integration, approved 11/8/10 and implemented 12/8/10; o Plan of Action, including outcome, action step, evidence, responsible person, dates, and status, for previous recommendation Section S #20; o CCSSLC Community Outing Preference Assessment (blank rubric); o CCSSLC Policy - Habilitation, Training, Education, and Skill Acquisition: Ensuring Opportunities for Day and Vocational Programming Away from the Unit, approved 11/8/10 and implemented 12/8/10; o Texas Department of Aging and Disability Services, Employment First Pilot, draft policy, not dated; o Provided PSP addendums related to PST meetings discussing barriers to participating in off-site day or vocational programming for Individual #153, Individual #83, Individual #234, Individual #311, Individual #36, Individual #270, Individual #6, Individual #122, Individual #179, Individual #196, and Individual #323; and o Comprehensive Functional Skills Assessment, draft version, dated 11/18/10. ▪ **Interviews with**: o Dr. Robert Cramer, Clinical Psychologist, on 1/3/11; o Iva Benson, Facility Director, and Mark Cazalas, Assistant Director of Programs, on 1/4/11; o Bruce Boswell, Director of Day Programs/Active Treatment and Interim Acting Director of Behavioral Services, Dr. Robert Cramer, Clinical Psychologist, and Everett Bush, Psychologist, on 1/4/11; o Bruce Boswell, Director of Day Programs and Active Treatment and Interim Director of Behavioral Services, and Rachel Rodriquez, QMRP Coordinator, on 1/5/11; o Dr. Robert Cramer, Clinical Psychologist, and Everett Bush, Psychologist, on 1/6/11; and o Bruce Boswell, Director of Day Programs and Active Treatment and Interim Director of Behavioral Services, on 1/6/11.

	▪ **Observations of**: o Observation and discussion with staff members at the Behavioral Support Committee (BSC) Meeting, on 1/4/11; o Observation and discussion with staff members at the Skill Acquisition Review Committee meeting, on 1/5/11; o Observation of Personal Support Team (PST) members at the Personal Support Plan (PSP) Meeting for Individual #338, on 1/6/11; o Onsite direct observation, including interaction with direct support professionals, and other professionals including residence coordinators, psychologists, psychology assistants, home team leaders and assistants, active treatment supervisors, active treatment specialists, and community integration specialists, vocational coordinators, rehabilitation therapy technicians, and/or QMRPs were conducted throughout the morning, day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Apartment 511 (Pompano), on 1/3/11 and 1/6/11; ▪ Apartment 517 (Angelfish), on 1/3/11 and 1/6/11; ▪ Apartment 514 (Dolphin), on 1/4/11 and 1/6/11; ▪ Apartment 518 (Porpoise), on 1/4/11 and 1/6/11; ▪ Annex and Canteen, on 1/5/11; ▪ Habilitation Therapies Building, on 1/5/11; ▪ Vocational Building, on 1/5/11; ▪ Adult Life Skills Building (512), on 1/5/11; ▪ Apartment 510 (Sailfish), on 1/5/11; ▪ Apartment 522B (Kingfish 2) on 1/5/11; ▪ Apartment 522A (Kingfish 1) on 1/5/11; ▪ Apartment 516 (Sanddollar), on 1/6/11; ▪ Apartment 515 (Seahorse), on 1/6/11; ▪ Apartment 522C (Kingfish 3), on 1/6/11; and ▪ Apartment 522D (Kingfish 4), on 1/6/11.
	Facility Self-Assessment: The Facility had developed a Plan of Improvement with regard to Section S of the Settlement Agreement. This POI contained outcomes, action steps, required evidence, facility target dates, completion status, judgment on current noncompliance (N) or substantial compliance (S), and additional comments. The Facility developed a self-assessment tool based on the Monitoring Teams' Section S rubric. Verbal reports indicated that staff members (including active treatment staff and QI/QA) had been completing record reviews regularly and that recent meetings (starting this past November) within the Active Treatment Department had been held to promote better integrity of implementation and agreement. As of the current Monitoring visit, it was reported that there was no summary data yet available for review. In addition to continuing to provide information about the actions taken to move toward compliance, it will be important as the Facility continues to strengthen its self-assessment process for data and analysis of the

	data to be included in the POI. According to the current POI, CCSSLC indicated that it was in noncompliance with all Sections within Habilitation, Training, Education, and Skill Acquisition Plans (Section S.1 to S.3). This finding was consistent with the Monitoring Team's review.
	Summary of Monitor's Assessment: Overall, progress was observed in many areas of habilitation, training, and skill acquisition programs. It was evident that administrative, clinical, and direct support professionals continued to be committed to improving the services and supports for the individuals at CCSSLC. Although changes were observed since the previous review, many areas still required additional work to adequately reach compliance with the SA. Since the Monitoring Team's last visit in July 2010, significant changes in the PSP process had occurred. This included changes within the development, implementation, and monitoring of skill acquisition programs. As anticipated, qualitative changes in the format of skill acquisition programs had occurred, as well as revisions in related responsibilities for their development, training and monitoring. Some of these changes were reflected in the recently revised CCSSLC policy entitled Habilitation, Training, Education, and Skill Acquisition: Implementing and Documenting Active Treatment Programs. At the time of the current Monitoring visit, summary reports indicated that over 190 skill acquisition plans had been developed using the new format for approximately 12% of the individuals at CCSSLC. Although the sample of reviewed programs demonstrated a significant improvement in quality over previously reviewed skill programs, concerns regarding critical elements with the plans remained. These concerns, identified within some skill acquisition plans, included: 1) the rationale for the specific plan, or in other words, the link between assessment results, PSP, and skill plan was not clear; 2) the adequacy of listed behavioral objectives and prompting hierarchies; 3) insufficient opportunities for teaching trials; 4) specification of discriminative stimuli; 5) instructions to staff regarding error correction; 6) use of differential reinforcement; 7) programming for generalization; and 8) limited diversity/flexibility within teaching methodology, including the use of backward chaining or total task presentation. Continued efforts to improve engagement also had been observed. Engagement was estimated at 76%, which reflected an improvement from the previous visit when it was estimated at 64%. Recent observations also evidenced more examples of formal teaching programs being implemented than previously noted. Summary of system-wide engagement data based on Facility measures, however, was not available for review. Efforts to support community integration also had continued including the availability of additional vehicles, as well as increase in the number of community-based skill acquisition programs. This was an area, however, that continued to require improvement, particularly with regard to the numbers of individuals involved, and the functionality of the objectives developed. Opportunities for on-campus and off home day programming and habilitation appeared to be progressing as well. Evidence suggested that PSTs recently had begun to actively problem-solve for some individuals who did not leave their homes. In addition, a more comprehensive vocational assessment had been

	developed and implemented. Concerns remained, however, with the inadequacy of assessment (i.e., objective data, situational assessments, and/or a thorough work history or interest inventory), and lack of individualization with regard to intervention. Concerns regarding the limited community-based options for competitive employment remained. Improvement in graphic display of data had continued since the last visit. However, concern about the accuracy and consistency of data collection remained. Similar concerns were noted with regard to adequate staff knowledge and implementation of skill programs. Until adequate levels of treatment integrity are evidenced, concerns regarding the accurate implementation of programming will remain.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Since the last Monitoring visit in July 2010, significant changes with regard to the development, implementation, and monitoring of skill acquisition programs had taken place. As anticipated, qualitative changes in the format of skill acquisition programs had occurred, as well as revisions in related responsibilities for their development, training and monitoring. Some of these changes were reflected in the recently revised CCSSLC policy entitled Habilitation, Training, Education, and Skill Acquisition: Implementing and Documenting Active Treatment Programs, dated 12/8/10. It should be noted, however, that this policy was still in draft form as the statewide skill acquisition work group was still developing a standardized skill acquisition plan format and related processes. According to Section S.1 of the CCSSLC Plan of Improvement, training of the new draft skill acquisition format as well as associated process was completed at CCSSLC on 10/31/10. Training documentation provided evidenced at least eight trainings since August on the new skill acquisition format and process, some of which included Behavioral Services Staff, both as trainers and trainees; active treatment coordinators; supervisors and specialists; program coordinators; nurses; and QMRPs. This new format and process was officially initiated on November 1, 2010 and, since that time (according to verbal reports), all PSPs had included skill acquisition programs using the new format. Subsequently, the PST was now responsible for identifying the targets of skill acquisition programs and the Active Treatment Program Coordinators were responsible for their development. Once developed, Active Treatment Supervisors primarily, and, in some cases, Psychologists/Assistant Psychologists or RN Case Managers trained direct support professionals. At the time of the Monitoring Team's recent visit, 190 skill acquisition programs plans had been developed for 34 (12%) individuals. A sample of these new plans were requested and reviewed, and is discussed in further detail below. The Monitoring Team recognizes the remarkable effort, coordination, and leadership that was necessary to support such a qualitative shift in the nature of skill acquisition programming. As this is a new process and format, the Monitoring Team also recognizes	Noncompliance

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		that the work completed to date reflected the first initial steps toward realization of this "paradigm" shift. The creation of the Skill Acquisition Review Committee appeared to be one way that staff would provide peer review and support while implementing this new format and process. Documentation provided and direct observation suggested that this committee provided the opportunity for critical feedback and ongoing support. Of the 34 individuals with PSPs conducted since November 1, 2010, a sample of 12 (35%) individuals was selected to review newly revised skill acquisition plans. This sample was selected from provided summary documentation (i.e., "Names and homes of 34 individuals for whom skill acquisition plans have been developed using the new format"). Since CCSSLC had significantly changed the format and process involved in developing, implementing and monitoring skill programs, previous skill acquisition objectives (SAOs), although still in place, were not reviewed. These older plans will continue to be replaced as PSPs continue to occur throughout the year. Of note, although summary documentation indicated that skill plans using the new format were developed for Individual #243 as part of his PSP dated 12/15/10, these were not provided with requested documentation. Of those sampled, it appeared that most individuals had, on average, five skill acquisition plans, with a range of four to seven. All of the individuals sampled had plans that were written following the newly revised format with the exception of Individual #244 who had two programs, tooth brushing and counting, that were written in the previous format. In general, the new format was significantly different from the previous version, and it appeared that CCSSLC active treatment and behavioral services staff were very responsive to earlier recommendations made by the Monitoring Team. More specifically, the new format included the addition of content areas targeting: 1) a task analysis; 2) specific teaching steps and conditions; 3) operational definitions of targeted responses; 4) schedules for training and data collection; 5) procedures following correct and incorrect responding; 6) strategies to promote generalization and maintenance; 7) specific identification of discriminative stimulus; 8) data summary sections, including graphs; and 9) a rationale highlighting the link between assessment and intervention. The revised skill acquisition plans reflected a qualitative change in format and process from the previous plans. In addition, different staff members had been charged with responsibility for developing, training, and monitoring these plans. As a result, staff at all levels within CCSSLC faced a steep learning curve as they proceeded with the implementation of this new system. As staff members continue to develop, implement and monitor these new plans, additional revisions and refinements are surely to occur over time. Perhaps not surprising, the Monitoring Teams' initial review of the first few of these plans revealed some errors, inadequacies and potential issues. These concerns, including examples, are explained below.	

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		All the reviewed skill acquisition plans identified a rationale (at the top of every plan) to explain why the plan was developed. Although this specific information was helpful in assisting the reader (including the Monitoring Team) to understand the link between the individual's underlying strengths and needs, as identified through assessments and the PSP process, at times, the information appeared inaccurate or incomplete. In some cases, even though a rationale was provided on all skill acquisition plans, the link between the assessment, PSP and skill plan, however, was still not evident. For example: ▪ The tooth brushing skill plan for Individual #246 clearly stated that the plan was developed based on needs identified in the PALS. The completed PALS, dated 10/5/10, did indeed reflect specific strengths and needs in this area. However, this information did not appear to be reflected anywhere within the completed PFW, dated 10/5/10, or the PSP, dated 11/9/10. More concerning, however, was the lack of correspondence between the PALS assessment and the developed skill acquisition plan. More specifically, the items identified as strengths or needs did not correspond to responses targeted for maintenance or acquisition, respectively. For example, the PALS clearly indicated that: 1) removing the cap, applying toothpaste, and holding the brush were areas of need; and 2) brushing all surfaces of the teeth was an area of strength. The skill acquisition program, however, targeted areas identified as strengths for acquisition and targeted areas identified as needs for maintenance. Therefore, based upon this limited review, it appeared that either the assessment or the developed task analysis was in error. ▪ A similar finding of inconsistency (or non-correspondence) between written skill programming and assessed skill was also evident during direct observation conducted by the Monitoring Team during a brief residential visit. More specifically, a direct support professional was observed assisting Individual #47 with his tooth brushing skill acquisition plan. During the observation, it was noted that staff did not encourage the individual to follow the specific sequence of the task analysis. Although this was problematic, it did not appear detrimental as the individual appeared capable of completing all of the steps of the task analysis (much beyond the step identified in the plan) with minimal staff assistance. Verbal reports from the staff indicated that concern regarding tooth brushing for Individual #47 was related less to skill deficits and more likely related to performance (motivation) issues. It appeared, then, that the skill program was either unnecessary or exceptionally effective since its implementation in November. ▪ The rationale provided for the medication identification skill program for Individual #255 indicated that it was developed based on preferences identified in the Medical/Health domain of the PFA. Examination of this section of the PFA,	

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		however, did not reveal any substantial information to support the need for this program. Medication identification was listed as an objective within Action Plan #1 in his PSP, dated 12/3/10. However, the rationale for identifying this as a target for skill acquisition was not obvious within PSP documentation. This finding is contrasted against another issue, quitting smoking, which was an obvious topic of discussion during the PSP meeting as a desire voiced by the individual, and an area in which the PST recommended support. However, subsequent supports to assist the individual to quit smoking were not identified within any action plans or in any skill programming objectives in the resulting PSP. ▪ The rationale provided for the adaptive equipment shower chair skill acquisition plan for Individual #251 was identified as the Adaptive Equipment Care Section (3.0) of the PALS. However, documentation provided, which included 11 completed sections of the PALS, did not include the Adaptive Equipment Care section. Subsequently, there was no evidence to reflect how this skill acquisition program was related to needs identified through the PALS assessment. A similar lack of evidence was found for a hand washing [pre-Self-Administration of Medication Skills (SAMS)] skill program for Individual #70. In this case, the rationale suggested that the plan was based on needs identified in the Bathing section of the undated PALS, which was not among the 10 completed sections provided. ▪ According to listed rationale, the sex education skill program for Individual #300 was developed based on needs identified in her Education and Training Assessment, dated 11/16/10. Subsequent examination of this assessment, however, did not reveal any needs other than "needs to attend class." At the time, it appeared that she had already been involved in the class and was being encouraged to continue despite documentation reflecting "no progress," poor attendance, and a rating of "no" in response to "does this individual appear to benefit from this class." It was unclear, based on this assessment, why she was encouraged to continue in a class that she actively avoided and had appeared to not benefit from attending. ▪ It was unclear how the skill acquisition plans targeting pre-money management (counting) and tooth brushing were related to the communication domain of the PFA for Individual #307. It was also unclear why the PST chose to teach the skill of "counting," including the subsequent task analysis step of "rote count to 5," to an individual with no expressive language ability. It appeared more likely that the plan would teach her to point to items presented to her. A similar acquisition program was implemented for another individual who did not communicate verbally (i.e., pre-money management program for Individual #70). ▪ Lastly, it was indicated that an adaptive switch skill program for Individual #244	

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		was based on Section 10.1 (Leisure Preferences) of the PALS. This program appeared to be designed to train a response that turned on a radio. However, a scored item on the PALS, dated 8/5/10, clearly indicated that the individual did not enjoy music, or watching television, and preferred to be outdoors. Further specification would have been helpful if she preferred listening, for example, to talk radio. At times, the objectives identified within the PSP were inconsistent with those written within skill plans. ▪ For example, the measurable steps identified in the PSP related to money management for Individual #42 were not the same objectives listed on the corresponding skill acquisition plan. Correspondence would likely improve if prerequisite assessments, in this case the money management task analysis, completed on 12/2/10, were completed prior to the PSP meeting, held on 11/17/10. In some cases, the identified behavioral objective could not be met as written. For example: ▪ As stated on the Choice Making skill acquisition skill plan for Individual #47, dated 11/1/10, to meet criterion, the individual would need to perform at a 50% level for five consecutive months. However, the date listed as part of the objective, February 28, 2011, would not allow enough time to meet the criterion. Lastly, consideration should be given to changing the criterion of 50% for five consecutive months. Typically, criteria are set higher, and five months is much too long to use for a criterion. ▪ If behavioral objectives are to be monitored monthly, the behavioral objective should reflect a measureable criterion that is reviewed and scored monthly (e.g., "… for 3 out of 4 trials per month for 3 consecutive months"). Examples of where this stated monthly rating was missing included the sex education skill plan for Individual #300, or the money management program for Individual #42. The criterions should be written with more flexibility allowing the criterion to be met much sooner. In some cases, the instructions included under the methodology were somewhat unclear or redundant. For example: ▪ Instructions for staff following a correct response were obviously in error (i.e., likely a product of mistaken "cut and paste") for Individual #251 in her adaptive equipment skill plan. The instructions referenced "bathing materials," which were obviously unrelated to the current program. ▪ Like other plans reviewed, the counting (pre-money management) skill acquisition plan for Individual #307 contained redundant information across	

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		different sections. For example, information describing the discriminative stimulus, instructions, and consequences for correct and incorrect responding were found repeatedly throughout the document. As noted in the recommendation section, it would be helpful to eliminate some of the redundancy within the skill plans thus making them more accessible to staff. In some cases, the task analysis was too broad (i.e., including several sophisticated skills) or included information better suited for other sections. For example: ▪ The choice making task analysis for Individual #47 outlined steps involved in generalizing a skill to other settings instead of promoting the mastering of discrete responses involved in correctly performing the entire skill. In some cases, the "fading sequence" or prompting hierarchy was incomplete or insufficient. For example: ▪ Only one prompt level (e.g., hand-over-hand) was listed within the fading sequence section of the pre-money management plan for Individual #307. It was unclear how staff might utilize less intrusive prompting (e.g., gestural or verbal), if she started to demonstrate the skill without the need of hand-over-hand assistance. Similar concerns were noted for other programs as well (e.g., pre-SAM skill program for Individual #70). The Facility should standardize (to some degree, but allowing individualization as necessary) a prompt hierarchy and the method in which staff utilize either more or less intrusive prompts following correct or incorrect responding. Some skill plans continued to prescribe only weekly opportunities to practice a targeted skill, bringing into question whether or not sufficient trials necessary for effective teaching were being offered. Indeed, if an individual refused to participate or an unanticipated event limited participation in the trial, it might be multiple weeks between teaching opportunities. Or, in some cases, the specific regimen of teaching trials was unclear. For example: ▪ The skill program targeting choice making for Individual #47 identified weekly training within the community. This might be too infrequent to occasion and reinforce correct responding. ▪ In some cases, it was unclear how often training would occur. For Individual #300, for example, it was stated that: "Training will occur during her SRB classes weekly …" Given this description, it was unclear if training occurred once a week or more. At times, the discriminative stimulus appeared vague and, subsequently, less likely to promote correct responding. For example: ▪ Individual #42 was to be told "… let's talk about money" along with a gesture	

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		toward money identification materials. This discriminative stimulus would be likely to occasion a wide variety of potential responses. The targeted skill, however, included money identification. In fact, the task analysis asked, for example, "… which one is the dollar bill?" In this case, the latter would be a more effective discriminate stimulus when initially teaching the response. Some skill programs did not include sufficient, adequate or accurate information to assist staff when responding to incorrect responses. For example: ▪ The medication identification program for Individual #255 encouraged nurses to inform him of the side effects of his medication when he cannot state them. After reminding him of the correct answer, it would be effective to offer the individual a subsequent opportunity to respond with the correct response. Similar opportunity to respond following correction would be beneficial for Individual #42 in her money management skill program as well. Indeed, this additional opportunity to respond correctly, even if prompted, would allow staff to reinforce correct responding. Consequently, a consistent error correction procedure would appear to benefit all individuals with skill plans. ▪ Instructions on skill plans were sometimes unclear. For example, if individual #251 incorrectly responded to step #4 on her shower chair skill acquisition program, it was unclear which type of prompt, either more verbal, gestural, or physical, should be utilized. Typically, the next more intrusive level of prompt is provided to support correct responding. ▪ It was unclear how, following an incorrect response when asked to identify the purpose for attending sexual education classes, prescribed gestural or physical prompts would assist Individual #300 in producing the correct response. According to the fading sequence and descriptions within the text, if she did not independently demonstrate a correct response, staff members assisted her using verbal, gestural, and/or physical prompts. However, the gestural and physical prompts were not identified. In this case, instead of gestural or physical prompts, the use of more concrete stimuli (e.g., written or picture) would likely be helpful in promoting correct verbal responding if prescribed verbal prompts were unsuccessful. ▪ In some cases, procedures within skill plans were simply incorrect. Error correction instructions on the pre-money management plan for Individual #307, for example, referred to hand washing and not the targeted response of counting. Often, skill plans provided inconsistent directions regarding data collection. For example: ▪ The medication identification skill plan for Individual #255 indicated that "testing will occur daily," while the included data sheet appeared to be set up for	

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		weekly data collection. ▪ Under the Teaching Schedule section, the pre-money management skill plan for Individual #307 indicated that: "Training will occur in the activity room," but did not prescribe when and/or how often the training should take place. In this case, the description in the Data Collection section that stated: "Testing will occur daily and can be practiced after every meal" was also ambiguous, did not match the data collection system that reflected weekly data collection, and did not appear related to the target response of counting objects. The use of differential reinforcement is critical to skill acquisition. The provision or withholding of reinforcers following correct and incorrect responding, respectively, is an important factor in effective skill acquisition. In some of the skill programs reviewed, however, the use of reinforcers following correct responding, either unprompted or prompted, was not obvious. For example: ▪ The prescribed verbal statement: "You turned on the radio. I know you like to listen to the radio!" following a correct response might have been the intended reinforcer (verbal praise) within the adaptive switch skill plan for Individual #244. However, it was not specifically stated and, consequently, it was unclear if this verbal statement was supposed to be verbal praise. Indeed, access to the radio might be the reinforcer. However, this was not stated as well. ▪ Other reviewed skill acquisition plans lacked specific reference to the use of reinforcement. For example, no specific reinforcer(s) was identified in the plan reviewed for Individual #70. ▪ When a reinforcer was described in the skill acquisition plans reviewed, verbal praise was the only type of reinforcer identified. That is, most plans prescribed the use of verbal praise following correct responding. One plan provided greater specification when using verbal praise. For example, direct support professionals were instructed to use the term "Hun," a preference of Individual #42, when praising correct responding. Two plans, however, outlined descriptions or confirmation of responding rather than enthusiastic praise for accurate performance. For example, after correctly pushing a switch, direct support professionals were instructed to state: "You turned on the radio. I know how much you like to listen to the radio!" for Individual #244. Staff instructions detailing more enthusiasm, such as: "Great job turning on the radio!" followed by access to the radio might be more effective. Also, following correct responding, staff were instructed to state to Individual #70: "I'm glad you washed your hands today …" The reinforcing quality of this verbal response did not appear much different than what was prescribed for incorrect responding. In general, although verbal praise can be an effective generalized reinforcer, individualized reinforcers, which might be more preferred, might increase the likelihood of skill acquisition.	

#	Summary of Provision	Assessment of Status	Compliance
		All the plans reviewed had information regarding generalization. Although generalization was addressed, the related description or procedure lacked sufficient specificity. That is, when describing programming for generalization, most plans only included a broad statement, such as: "… this learning can be generalized to any independent living situation." It would be more helpful to include more individualized strategies to support generalization of skills across different staff, different situations, and/or different discriminative stimuli. For example: ▪ Individual #251 had a skill acquisition program involving holding onto staff during a stand-pivot while showering. When describing procedures that would support generalization, more specific instructions could include the identification of other settings in which this skill could be performed and reinforced (e.g., stand-pivot from her wheelchair to her bed, couch, etc.). ▪ The generalization procedure described in a tooth brushing program for Individual #70 suggested a connection between tooth brushing and hand washing. It was unclear how this connection demonstrated generalization of tooth brushing responses. ▪ One reviewed plan, however, appropriately prescribed situations in which the new skill could be generalized to other settings and across other devices. This was the adaptive switch skill acquisition program for Individual #244. With the exception of one skill acquisition plan, all of the plans reviewed utilized forward chaining. The exception, a pre-SAMS skill acquisition plan for Individual #70, utilized backward chaining to teach hand washing. Backward chaining is often preferred to forward chaining as the individual completes the entire chain during every trial. Plus, in some cases, access to a natural reinforcer following correct responding is more immediate. Like backward chaining, total task presentation allows a learner to complete the entire chain (i.e., total task) in each learning trial. It is unclear why backward chaining and total task presentation were not found more often in the sampled skill acquisition plans. With an understanding the PSP process had recently undergone a qualitative change as well, it was still unclear whether or not individual preferences ultimately helped determine, shape, and/or encourage (reinforce) correct responding within many of the skill plans reviewed. For example: ▪ It was very difficult to identify why Individual #300 was being encouraged to attend sex education classes. Referenced assessments as well as her PSP did not provide an obvious rationale, based on identified need or preference, for her participation in this class. What was clear, however, was that she did not appear to attend, participate, or benefit from the class.	

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		The recently implemented new PSP process certainly appeared to be focused on identifying individual's preferences and interests. Indeed, a central focus of the new PSP process was for these identified preferences and interests to shape the PST's vision for the individual. In addition, the new PFA and PSP process included a new process for the identification of selected assessments. However, it was still unclear how the PST prioritized identified needs and determined which needs would be addressed though corresponding skill acquisition plans. For example ▪ Review of the PSP for Individual #42 indicated that the she was at risk for aspiration (she had a significant incident involving choking in the past) while eating. Based solely on the PST discussion of the PFW as described in the first two paragraphs of the PSP, it would seem likely that she would have a skill plan targeting eating at a slower pace. However, this was identified as a Staff Service Objective (SSO), not a more formal skill program. Similarly to previous visits, observations during the January 2011 site visit evidenced a continued effort to promote engagement in recreational, leisure and other activities, including opportunities for community outings, across all residential programs. The Monitoring Team estimated levels of engagement across many residences and programs at multiple times across days and times of day. Engagement was measured by briefly observing the individuals who were engaged at the moment and the number of staff available at that time. The definition of engagement was very liberal and included active (e.g., painting, coloring, building mosaics, playing Uno, etc.) and passive forms (e.g., listening to music, watching TV, listening to instructions regarding a craft being made, etc.) of engagement. The table below provides specific information on observed estimated level of engagement (individuals engaged: total number of individuals) in relation to staff-to-individual ratios across residential programs. Engagement Observations	

Location	Engaged	Staff-to-Individual Ratio
Pompano	1:1	3:1
Pompano	1:1	2:1
Angelfish	3:3	2:3
Angelfish	1:1	0:1
Dolphin	1:1	2:1
Dolphin	2:2	3:2
Dolphin	3:3	1:3
Porpoise	1:1	1:1
Vocational Building	3:3	1:3
Kingfish 2	0:2	0:2

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		(see table and text below)	

Kingfish 1	--	1:6
Seahorse	--	1:6
Seahorse	3:5	1:5
Kingfish 3	0:2	0:2
Kingfish 3	3:8	2:8
Kingfish 4	3:3	1:3
Kingfish 4	2:2	1:2
Pompano	6:6	2:6
Angelfish	1:1	1:1

Overall engagement was 76%. An engagement level of at least 75% would be a typical target for a facility like CCSSLC. Subsequently, it was obvious that the staff had been well trained to encourage individual engagement. In general, direct observations suggested that many staff diligently worked to keep individuals engaged by offering opportunities to participate in a diverse array of activities. At times, when engagement was less than ideal, the staffing ratios were at their lowest. And, in some cases, engagement was difficult to accurately assess. For example, individuals might have been in a room where the television or music was on, and it was difficult to accurately estimate if they were listening or watching. In most of these cases, the "benefit of the doubt" was given (i.e., that they were engaged) unless they had their eyes closed or were not consistently orientated toward the television. In addition to the frequent observation of individuals engaged in leisure or recreational activities, individuals also were observed participating in more formal skill programs. One example included Individual #267 enthusiastically working with staff on letter identification.

Based on the Monitoring Team's direct observations during the recent onsite visit as well as verbal reports from Active Treatment staff members indicated that engagement continued to be monitored actively. Indeed, during one brief residential visit by the Monitoring Team (i.e., Apartment 511 on 1/3/11), a staff member was on hand to complete a "5 Minute Engagement Monitoring Form." It appeared that these monitoring observations provided an opportunity to estimate engagement, but also to provide coaching to staff as appropriate. As noted in Section S.1 on the Plan of Improvement, as of 9/27/10, 64 engagement monitoring forms were completed with an average engagement score of 73%. However, as noted on the POI, it was discovered that the tool was not being implemented with integrity and, subsequently, likely overestimated engagement scores in some programs within the Atlantic unit. Documentation provided indicated that staff training was completed on (12/28/10 to ensure that staff implemented the tool as designed. At the time of the Monitor's visit, verbal reports indicated that the available engagement data had not yet been fully analyzed and that a closer examination of the data was anticipated later in January. According to the

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		provided action plan, unit-based active treatment committees as well as data-based trend analysis of engagement scores was scheduled to begin in January. Documentation provided during the previous Monitoring visit included the draft policy of Habilitation, Training, Education, and Skill Acquisition: Ensuring Facility Engagement, dated 7/8/10. At that time, it appeared that this policy was developed to promote engagement across all residences as well as day and vocational programming. According to the policy, engagement criteria had been identified as 80% and 60% within day programs and residences, respectively. When engagement fell below these levels, the Active Treatment Engagement Team was required to meet and develop additional training or resources. At the time of the Monitoring Team's most recent visit, verbal reports indicated that these meetings had not yet occurred, because the data had yet to be examined. Subsequently, it appeared that only coaching had been occurring in response to engagement monitoring. As the provided examples indicated, staff members were documenting the nature of coaching when implemented. However, like the engagement estimates, this data did not appear to have been summarized. Of note, as of the most recent Monitoring Team visit, the previously available draft policy, Habilitation, Training, Education, and Skill Acquisition: Ensuring Facility Engagement, dated 7/8/10), was not included with other current policies (i.e., listed within Section S). As a result, it was unclear if this policy was still in place. Verbal reports, however, continued to reflect a similar expectation that these monitoring forms be collected at each residence twice per week. Requested documentation on completed community outings demonstrated a continued emphasis on encouraging individuals to access their communities. That is, as similarly observed during the previous review, the monthly residential data reflected considerable frequencies of outings as well as variability in the number of outings individuals participated in per month. Average number (and range) of community outings per month for June, July, August, September, October, and November across all residential programs was 45 (three to 128), 50 (three to 102), 49 (four to 133), 46 (eight to 97), 52 (three to 108), and 29 (three to 71), respectively. The average number of community outings per residence across months for the past six months evidenced an even larger range of four to 108. In general, the number of community outings across the last six months did not appear to reflect any consistent increasing or decreasing trend for any of the programs. Consideration should be given to monitoring these summary data over time to ensure adequate levels of community integration across all programs. Interestingly, however, community outings across all programs decreased from October to November 2010. This finding was somewhat counterintuitive as new vehicles were available starting November 1st. An additional surprising finding was the number of medical appointments that individuals participated in as community or off-campus outings. Indeed, over 50% of the monthly outings, between June and November 2010,	

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		were related to medical appointments for several residential programs, including Apartment 503, Apartment 515, and Apartment 516. Similarly, over 33% of the monthly outings, between June and November 2010, were related to medical appointments for several residences, including Apartment 522C, Apartment 524A, Apartment 524B, Apartment 524C, and 524D. In some cases, 100% of monthly off-campus activities were medical appointments. This was true, for example, for the July and November outing summary for Apartment 516, as well as November outing summary for Apartment 515. The off-campus data provided was typically summarized by residence each month and included the names of individuals, the number of outings for each individual listed, and the number of outings for each identified location. Although this information was very helpful in tracking community outings for individuals and residential programs, the format limited a more comprehensive understanding of the nature of community integration. That is, information pertaining to individuals who did not go out into the community was not presented. Therefore, it was difficult to determine if monthly totals included all individuals within a specific residence. It would be helpful to include additional descriptive statistics, such as the range, mean, median, and/or mode, for each residence to assist with interpretation of the data. These additional descriptors would be very helpful in understanding the nature of community integration of residences that have a large range of outings per week (or month). According to provided documentation, it appeared that community outings were closely monitored via the weekly community activity reports. A process also was in place (i.e., Unit-based PIT report) to provide corrective feedback to programs when community integration was not sufficient. In addition, according to current policy on ensuring community integration, an annual assessment using the Community Outing Preference Assessment was prescribed to facilitate the identification of meaningful community-based settings and activities for each individual. The Monitoring Team understood that this assessment was to be completed as part of the PSP process. These assessments were not included as part of the current review and will need to be more closely examined in future reviews. As found during previous Monitoring visits, the current day and vocational habilitation and sheltered work programs on campus offered individuals opportunities for meaningful work. This included work on and off campus in enclave or supported employment positions. Previous reviews, however, noted concerns with: 1) the goals and objectives that individuals' PSPs included with regard to day and/or vocational activities; 2) the provision of day program options for people with more complex needs; and 3) the limited opportunities for individuals to work off campus in competitive employment positions.	

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		At the last Monitoring visit, it was learned that, in an effort to address identified concerns, a newly revised, more structured and comprehensive Vocational Assessment was being piloted. At the time of the previous review, only one revised vocational assessment had been completed. Documentation provided during the most recent review indicated that 26 revised vocational assessments had been completed. It should be noted that this assessment was still considered a draft and in the pilot stage. The vocational assessment process is discussed in further detail in the section below that addresses Section S.2 of the SA. As previously noted, the utility of the new Vocational Assessment will only be optimized if its findings are well integrated within adequate, meaningful and functional skill acquisition programs. As noted in S.1 of the SA, qualitative changes in policy, content and process associated with skill acquisition programs had occurred recently. Consequently, the PST as well as the new Vocational Assessment Review Committee should make very specific recommendations balanced against the overall vision for the Individual, based on this assessment, regarding targeted skill development that will promote and maintain active participation in vocational settings. At the baseline review, it was identified that a number of individuals did not leave their residence to attend day program. For many of these individuals, this limitation did not appear to be a result of medical restrictions. At the time of the last review, PSTs had reviewed the barriers to attending day programs (away from individuals' homes) and had identified a number limiting variables, including the need for: 1) transportation; 2) adequate programming space; and 3) onsite nursing support to provide necessary medical interventions. As presented below, with regard to Section S.3 of the SA, progress had been made in improving transportation availability and access to public transportation. In addition, progress had continued in developing programming settings on campus for individuals to participate in day/vocational programs out of their homes. Previously, programming space had been developed in the Pacific residence and the Bike Shop on campus was opened. Currently, according to verbal report and observation, residents within the Atlantic Unit were attending day programming and vocational habilitation at the Adult Life Skills (ALS) Building. This move to the ALS building was a recent change in December 2010. Some individuals from the Coral Sea program were attending day services in the Gymnasium. The programming space at the gymnasium, however, was reported as unsatisfactory to CCSSLC staff and a future move to a new setting appeared likely. In addition, plans were underway to relocate Pacific residents to newly renovated space within the Sailfish building. According to the Director of Day Service and Active Treatment, it was anticipated that approximately 30 individuals from Pacific would be "enrolled" at Pacific by March 2010. Overall, it appeared that primary efforts to identify	

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		day programming and vocational work sites had focused on on-campus settings, and based on a brief walk through of the programs, it appeared that progress in this regard was being made. There was evidence based on review of documentation that PSTs had started the process of identifying variables that prohibited individuals from participating in off-site day/vocational programs. Review of eleven PSP addendums, including those for Individual #153, Individual #83, Individual #234, Individual #311, Individual #36, Individual #270, Individual #6, Individual #122, Individual #179, Individual #196, and Individual #323 indicated that many of these meetings occurred just recently (i.e., during the last week of December 2010). Meeting minutes for most of the individuals appeared to indicate that these were the first PST meetings held to address underlying concerns. ▪ Four of the PSP addendums (for Individual #153, Individual #83, Individual #23, and Individual #311) reflected meetings held on 12/31/10, during which the PST recommended a vocational consultation and utilization of recently developed desensitization programs. Initial review of the desensitization plans, however, suggested a lack of individualization. In addition, it was unclear how calming strategies designed for dental/medical procedures would transfer effectively to a much different work environment. ▪ Four of the PSP addendums (for Individual #234, Individual #311, Individual #196, and Individual #323) described intervention strategies that appeared individualized. ▪ Four of the PSP addendums (for Individual #270, Individual #6, Individual #122, and, Individual #179) indicated that individuals could not attend programming outside of their residence due to required medical intervention (continual 02 treatments) that was not available at the day site. It was unclear from any of the PSP addendums if this support could be arranged (or was being arranged) within the day setting. PSTs determined to monitor each individual's need for this treatment and re-evaluate participation in programming if their status changed. PSTs are strongly encouraged to continue to monitor identified reasons and justifications regularly and, when appropriate, develop individualized interventions to support individuals in accessing programming outside of their residential programs.	
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	During previous reviews, the Personal Focus Worksheet: Individualized Assessment Screening Tool (PFW) was annually completed and discussed concurrent with the PSP for each individual served at the Facility. Recent changes within the PSP process, however, had led to the replacement of the PFW with the Personal Focus Assessment (PFA). The PFA was described as a more comprehensive assessment that, like the PFW, facilitated the identification of an individual's goals, interests, likes/dislikes,	Noncompliance

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	of living, working, and engaging in leisure activities.	achievements and lifestyle preferences across a wide range of areas. Ultimately, this assessment was intended to inform the PSP planning process by functioning as the primary screening device that assisted with the identification of necessary assessments. The PFA assessment officially replaced the PFW in October 2010 when the new PSP process was put into place. Subsequently, PSPs that occurred in November were to have the new PFA completed. However, as described below, several PSPs conducted in or after November 2010 did not utilize the new PFA assessment. Of the 23 individuals selected for review, 19 (83%) had either the PFW or the PFA completed within the last year. Although completed, the PFA for Individual #255 was not dated. That is, PFWs or PFAs were not available, as requested, for Individual #145, Individual #244, Individual #275, and Individual #312. Of the 23 sampled, six individuals had PFAs completed as part of the new PSP process (i.e. their PSP meetings had occurred since October 2010). Of the six PFAs sampled, two (33%) appeared to be fully completed (Individual #70 and Individual #297). Of the remaining four incomplete PFAs, one of the reports (Individual #145) did not indicate which assessments were recommended for completion and several did not provide any summary (Individual #145, Individual #307, Individual #243, and Individual #300). In addition, PST signatures were missing on the PFA for Individual #145. For several individuals with PSPs held in November, the older PFW assessment was completed (Individual #311, Individual #251, Individual #246, Individual #333, and Individual #42). It was likely that the PFW, in these cases, was completed in September or October, prior to the formal start date of the new PSP process. As noted in previous reports, the Positive Adaptive Living Skills (PALS) assessment was completed for each individual concurrent with their annual PSP meeting. The PALS was used to assess a number of skill areas, as well as to identify additional information on individuals' preferences, strengths, skills, and needs. Of the 23 individuals sampled, 22 out of 23 (96%) evidenced completion of a PALS assessment within the last year. There was not a PALS provided for Individual #243. Of the completed reports, three were not dated (i.e., Individual #255, Individual #70, and Individual #333). In addition, the completion of the PALS for some individuals had occurred after the PSP meeting. More specifically, the dates on some PALS reflected that it was completed after the PSP meeting (Individual #145, Individual #244, and Individual #311). This was likely unhelpful given that the findings of the PALS (strengths, needs, etc.) were typically utilized by the PST to inform the PSP. It appeared that some of the sampled PALS were completed accurately, while others were not. Of the six individuals with PFAs completed as part of their PSPs, three (50%) appeared to be completed accurately. That is, the sections completed on the PALS	

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		corresponded with those sections recommended for completion on the PFA (i.e., Individual #297, Individual #70, and Individual 307). For others, however, the scored PALS did not appear to be completed as intended or did not appear adequately completed. For example, the sections of the PALS, dated 10/20/10, completed for Individual #300, were not the sections identified for completion on the PFA. Indeed, none of the seven sections identified for completion on the PFA, dated 10/20/10, were included within the submitted PALS. It should be noted that for Individual #255, it was not possible to assess if the PALS was completed as intended, because the PFA did not indicate which assessments should be completed. Similarly, it was not possible to assess if the PALS was completed as intended because it was not provided for review as requested for Individual #243. As previously described, significant changes had occurred within the PSP process in the last six months. This change had included the revisions of policies, assessments, and skill acquisition plans, as well as in the roles and responsibilities of PST members, especially the QMRPs and active treatment staff (i.e., program coordinators, supervisors, etc.). Several changes that had occurred, but that were not closely examined at this time were the implementation of the Education and Training Assessment and the Community Outing Preference Assessment. The later assessment was referenced in the most recently revised CCSSLC Habilitation, Training, Education, and Skill Acquisition policy for Ensuring Community Integration. It was unclear if this new assessment had replaced the previously utilized Community Inclusion Assessment. The Monitoring Team did not find reference to the Education and Training Assessment in any of the available policies. Review of these two assessments will be completed during future reviews. Verbal reports from the Director of Active Treatment indicated that the PALS assessment was likely to be replaced in the near future with another assessment, called the Functional Skills Assessment. Reportedly, a statewide work group developed an initial draft and feedback was being solicited from the SSLCs and the Monitoring Teams. Future reviews will need to assess how this assessment will be integrated into the current PSP process. Lastly, continued progress had been observed in the area of vocational assessment. As found at the time of the previous review, a revised Vocational Assessment had just been developed and was being initiated as part of a pilot project. Compared to the previous assessment, this revised rubric was a more comprehensive eleven-page structured assessment that prompted respondents to answer items across a number of skill areas, as well as questions regarding personal preferences and individual characteristics. At that time, only one assessment had been completed. Currently, reports indicated that this revised vocational assessment had been completed with at least 26 individuals. Reports also indicated that the Vocational Assessment Review Committee met	

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		approximately ten times between November and December 2010. Documentation also indicated that vocational staff members, those responsible for the completion of the draft vocational assessments, had been trained on 10/26/10. A sample of six (23%) vocational assessments was reviewed from the total of 26 that were completed. All (100%) of the vocational assessments reviewed appeared completed as prescribed and consistent with vocational assessment review committee minutes. However, concerns related to the adequacy of the assessments to provide teams with the necessary information with which to develop action plans related to individuals' vocational preferences and needs were noted. As discussed above with regard to Section F.1.c: ▪ Individual #62's PSP indicated that he had poor attendance at work. He worked at the Annex on the hangers and rags jobs. At his Personal Focus Assessment meeting, he indicated that he would like to work for a cell phone company. Prior to the PFA meeting, a vocational assessment was completed. It was unclear from the assessment what methodologies were used to complete it. For example, the assessment did not indicate if the assessor used interviews with the individual and/or staff who had worked with him, observations, record review, formal testing, and/or situational assessments to gather the information used in the report. The assessment included summary statements regarding Individual #62's Vocational/Employment Vision, Obstacles to Employment Vision, and Work Preferences. However, because the methodology used was not clear, the conclusions drawn were questionable. For example, the Vocational/Employment Vision indicated that: "[Individual #62's] vision is to continue working to make money to pay for his cell phone and buy his game electronics. He would like to move out of the state school and work indoors being an office assistant." It was uncertain if this vision was based on Individual #62's limited exposure to jobs that might be available, or if situational assessments had been utilized to provide Individual #62 with some experience with different types of jobs that might be available to him. The Preferences section provided a little more information about the nature of work the assessor had determined Individual #62 might be successful doing, including working in a small work setting, with moderate supervision, and a part-time job that was moderately physical in nature. Again, it was not clear what methodologies were used to draw these conclusions. The only obstacle listed for attaining his employment vision was "Lack of motivation." No information was provided about what motivated Individual #62, or how these motivating factors might be used to increase his participation in work. There was no evidence that his team discussed this further at his PSP meeting. It did not appear that the assessor or team had given any consideration to whether the lack of motivation was in relation to the specific job options that had been made available to Individual #62. Moreover, the only recommendation included in the Vocational Assessment was: "[Individual #62] will count	

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		hangers in increments of 300 and place them on the rack with the correct label." The team did not include this objective in his PSP, and, in fact, the PSP included vocational objectives that bore no relationship with the findings of the Vocational Assessment. The team included in the PSP objectives related to learning how to dress when going to work, proper hygiene for work, and learning that each job required different clothing. These were not areas that had been identified in the Vocational Assessment as problematic. In summary, Individual #62's vocational assessment did not provide his team with a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history, or interest inventory. This limited the team's ability to develop a plan to assist Individual #62 to reach his employment goals. ▪ Likewise, Individual #251's vocational assessment did not represent a vocational profile based on objective data, situational assessments, and/or a thorough work history, or interest inventory. As a result, it did not provide her team with an adequate vision of the type of employment that should be sought for her. For example, her Vocational Employment Vision was stated as: "[Individual #251's] vision is to live closer to her family in… Texas and be able to continue working at a similar job like she is doing here (working assembly – paper shredding/cleaning) and make money to buy her hair products." The only recommendation included in the Vocational Assessment was for the following skill acquisition plan: "[Individual #251] will work on weighing her own paper to shred in increments of 2 lbs using the electric scale." Part of the assessment listed previous work history. The only items checked were paper cleaning and paper shredding. This was an indication that Individual #251 had extremely limited exposure to potential jobs. Situational assessments would have been an appropriate option for allowing her to determine where her employment interests lay, as well as an opportunity for the assessor to better evaluate her skills in various areas. Although the vocational assessment identified many positive work habits and employment characteristics, the resulting recommendation did not lead the team to consider other vocational opportunities or training for Individual #251. The vocational assessment pilot should continue, but with a focus on developing a vocational profile based on objective data, situational assessments, and/or a thorough work history, or interest inventory. Assessments should result in information and recommendations that assist teams in considering a full array of vocational options that would lead a person toward their vocational vision, and developing action plans to assist the individual in reaching that vision.	

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S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As previously presented, a new skill acquisition format and process had recently been developed, trained, and implemented. A new PSP process also had been developed, trained, and implemented. Both of these processes included qualitative changes in content, processes, and formats of documentation as well as substantial changes in the roles and responsibilities of several PST members. Indeed, the changes had been significant, they occurred concurrently, and many of the new procedures were implemented just prior to the Monitoring Team's most recent on-site visit. It should not be surprising, then, that there were a few "bumps in the road" as many professional and direct support professionals attempted to negotiate the learning curve demanded by all of the recent changes. Based on verbal reports and documentation review (for specific details see information related to Sections S.1 and S.2.), it appeared that the identification and completion of assessments, the integration of related assessment findings within the PSP, and the subsequent identification and prioritization of objectives and related skill acquisition programs continued to be problematic. In addition, only a fraction of the individuals who resided at CCSSLC had gone through the new PSP process. Indeed, although a substantial number (190) of new skill acquisition programs had been implemented, it still only represented a small percentage of individuals (12%) served at CCSSLC. And, with any new system, it appeared that there were areas where further revision and "polishing" was in order. As a result, at the time of the Monitoring Team's review, it did not appear that the current strategies and supports effectively addressed all of the individual's needs for services and supports. However, verbal reports from the QMRP Coordinator indicated that a new PSP Committee was being organized and would soon meet to discuss refining aspects of the new PSP process, including an examination of how assessment findings were summarized, integrated, and linked to action plans and subsequent programming and supports. Due to the fact that the new skill acquisition programs had only been implemented since November (or after), performance data on these plans was not readily available for current review. Examination of previous PSP monthly reviews and/or actual skill plans (SPOs) of 23 individuals selected for review, however, indicated that documentation for	Noncompliance

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		22 out of 23 (96%) included graphs to display skill acquisition data. The only documentation that did not was for Individual #305. In addition, master copies of revised skill acquisition plans all contained areas for data collection and graphic display. Although the current system appeared ready to use graphic displays similar to what was done in the past, the absence of skill program data displayed on graphs did not permit examination and/or judgment of the program's effectiveness. Similar to findings from previous on-site Monitoring visits, current observations revealed concern with the consistency of data collection. Brief random record reviews indicated that data was missing from oral hygiene skill plans for Individual #92, Individual #255, Individual #246, and Individual #47 (for January). For one of the individuals, Individual#47, 90% of the data had not been recorded. It should also be noted that many of the records reviewed did not have any data collected yet for skill acquisition programs that prescribed weekly data collection. Because on site record review occurred the first week of the month (i.e., 1/4/10 to 1/6/10) and, theoretically, given the fact that staff still had one or more days (depending upon how "week" is defined) left to collect data, the information was not technically missing. Nonetheless, it appeared that no prescribed weekly skill acquisition data had yet been collected (during the first five or six days of the month) for Individual #251, Individual #348, Individual #307, Individual #42, Individual #311, and Individual #243. These findings, along with concerns previously described regarding data collection for PBSPs (discussed with regard to Section K.4), indicated that data collection was still somewhat inconsistent. As found during previous visits, discussions with direct support professional during on-site visits again produced mixed results in estimating the degree of treatment integrity of skill acquisition plans as well as PBSPs. Some staff reported accurate information regarding PBSPs and skill training programs, while others were either unsure or inaccurate in their descriptions of components of skill acquisition or behavioral supports. Like last time, some direct support professionals asked to be able to consult relevant documentation prior to answering questions. At times, even with the relevant documentation, some staff still had difficulty answering rather straightforward questions regarding programming. These observations, along with other noted concerns regarding data collection (discussed with regard to Section K.10) and treatment integrity (discussed with regard to Section K.11), resulted in mixed findings in the degree of staff's knowledge regarding skill acquisition and behavioral programming for individuals living at CCSSLC. The effective utilization of reinforcement strategies, including the routine use of reinforcers, continued to be somewhat problematic. More specifically, documentation review, including PBSPs and skill acquisition plans, continued to reflect the use of verbal praise as the typical and only reinforcer following correct responding. Unfortunately, the	

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		use of individualized reinforcers was rare across reviewed PBSPs and skill acquisition plans. Verbal reports from active treatment staff as well as behavioral services staff indicated that informal and/or formal preference assessments were not routinely completed. The obvious specification of differential reinforcement in response to correct and incorrect responding was not specifically described in skill acquisition programs. More specifically, the use of reinforcement following correct responding was not always conspicuous. In addition, as presented in Section K.9 of the SA, PBSPs did not commonly employ specific differential reinforcement strategies, for example, Differential Reinforcement of Alternative Behavior (DRA) or Differential Reinforcement of Other Behavior (DRO). In general, the use of reinforcement did not appear to be optimized within current programming. As highlighted in the previous report, concerns were noted with regard to expectations of individuals' participation in day/vocational programs. At the time, there appeared to be an emphasis on individuals' choice and limited regard for how it might limit individual's normalization or opportunities for training, especially in community settings. At the time of the most recent review, it was unclear how CCSSLC responded to this concern at a systems level. That is, documentation provided offered some evidence that PST teams were working to overcome obstacles that kept some individuals at home rather than at work (additional discussion is found with regard to Section S.1). However, it is unknown whether or not a larger collaborative approach across disciplines and administration had been taken to ameliorate this seemingly pervasive issue. In addition, it was unclear if specific data was collected and monitored regarding the nature of this issue.	
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the baseline review, documentation indicated that most individuals did not have substantial opportunities to engage in skill acquisition programs in community settings. Documentation from the last review (in July), however, indicated that progress had been started in promoting and supporting skill acquisition in community settings. At that time, approximately eight percent (8%) of all individuals at CCSSLC had skill acquisition programs designed to be implemented in community settings. Current documentation indicated that, as of the most recent review, 86 out of 284 (30%) of all individuals at CCSSLC had skill acquisition programs designed to be implemented in community settings. Although this still represented a relatively small percentage of individuals, it showed improvement. In an effort to confirm this summary data, the PSP and skill acquisition plans were reviewed for eight individuals who were among the 86 listed. Based on available documentation, six of the eight (75%) evidenced skill acquisition plans targeting implementation in the community. Two of the eight sampled individuals (i.e., Individual	Noncompliance

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		#307 and Individual #333) did not appear to have skill acquisition plans specifically targeting community settings. Although there was some inconsistency found within documentation provided, the substantial increase in community-based skill programming over the past year definitely demonstrates an improvement. At the time of the baseline review, it was determined that a limited number of individuals (approximately seven to twelve) held supported employment positions within community-based sites, including janitorial and lawn services for state and private business and residences. At the last review, based on verbal reports and summary data on individuals employed on and off campus (between 12/09 and 5/10), it was determined that the number of individuals in community based supportive employment positions (nine) had not significantly changed. At the time of the most recent review, verbal report and provided documentation indicated that 11 individuals were participating in community based supported employment. Subsequently, it appeared that an additional two individuals had secured employment off-campus since the Monitoring Team's last visit. One change that was likely to facilitate this process in the future was CCSSLC's recent decision (in December 2010) to join the statewide Employment First Initiative pilot program. This collaborative effort between the Texas Department of Aging and Disability Services (DADS) and local community-based providers should enhance opportunities for individuals at CCSSLC to obtain competitive employment positions. Verbal reports from the Director of Active Treatment reflected a belief that this program would enhance his team's ability to successfully support individuals in employment settings in the community. One of the primary challenges to community integration identified during the baseline visit was the limited availability of transportation. As indicated at that time, as more and more individuals worked on community-based objectives, increasing numbers of vehicles or access to public transportation would be needed. At the previous review, verbal reports indicated that CCSSLC would be purchasing additional vans and that these were expected to be available in September 2010. Current documentation indicated that three new vans were allocated as of November 1, 2010 to support community integration activities and supported employment. In addition, at the previous review, CCSSLC reported negotiating with the public transportation system in Corpus Christi to increase the availability of public transportation options to the individuals served. At the time of the most recent review, documentation showed at least 17 individuals had utilized public transportation for outings between 9/1/10 and 12/31/10. Provided data indicated that, on average, nine outings per month (range of five to 13) were supported by public transportation. As described earlier with regard to Section S.1, CCSSLC had demonstrated progress over	

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		the past year in establishing the foundation necessary to support regular community integration in terms of leisure and recreational activities, as well as opportunities to participate in skill acquisition for a limited number of individuals. Progress had been noted, although to a lesser extent, in supporting competitive employment in the community. On 11/8/10, the CCSSLC policy of Ensuring Community Integration was approved, and implemented on 12/8/10. With a consistent policy in place as well as the additional supports mentioned above, it appeared that CCSSLC was well positioned to continue their success. CCSSLC is encouraged to continue its efforts to ensure that individuals' PSPs include training opportunities in community settings to the degree practicable.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. With regard to skill acquisition programs:
    a. Continue to conspicuously describe the rationale for each skill acquisition program. This includes ensuring that the rationale is accurate, complete, and consistent with the PALS, PFA and/or PSP.
    b. In addition, ensure that the rationale very briefly highlights how an identified preference or need was addressed or included in the program (i.e., unless this information is conspicuously outlined in the PSP). For example, a preferred activity could be identified as the prescribed reinforcer.
    c. "Test trial" each developed or selected task analysis through direct observation (i.e., observe the individual trying the new skill when supported by staff) and individualize, as appropriate. This should be completed prior to implementing (training) the skill program.
    d. Completion dates that are individualized should be utilized to facilitate more frequent monitoring of performance.
    e. Eliminate the identification of specific prompt levels within behavioral objective, because this appears to necessitate more frequent revisions of the program. If including reference to a prompt level is desired, consider using something more general (e.g., "… at the specified prompt level") in the behavioral objective and prescribe/track the necessary prompt level on the data sheet. However, in the end, it might be more efficient to assume (and perhaps indicate) an independent level of responding (following the initial instruction) when writing most behavioral objectives.
    f. Use a more flexible and immediate criterion within behavioral objectives. That is, the commonly observed "… for 3 consecutive months" criterion is much too long when performance improves quickly or not at all. An alternative criterion, for example, could include a level of performance for "three consecutive trials."
    g. Avoid redundancy of information across sections in the skill acquisition plans. It is assumed that, with frequent use/repetition, staff will learn the format of the plans and know where to look for information. Instructions, discriminative stimuli, error correction or reinforcement procedures, for example, are not necessary under the methodology section if they are sufficiently described in other sections. Clear and concise plans will be easier for staff to read, comprehend, and correctly implement.
    h. Ensure that each task analysis is not overly comprehensive (i.e., not trying to do too much). That is, some of the reviewed task analyses appeared to include two or more complex tasks and, subsequently, not enough specification on stimulus-response chains to support effective teaching.
    i. Programming for generalization should include more specification regarding the procedures used to promote generalization. It is not sufficient to merely suggest that the skills are likely to generalize to any independent living situation. In fact, research suggests that new skills are not necessarily likely to generalize to other settings, people, other stimuli, etc., once learned.

j. Similarly, programming for maintenance should include more specification.
k. Standardize the "fading sequence" or prompt hierarchy found in all skill acquisition plans. The hierarchy could include the following response prompts, from least-to-most level of intrusiveness: 1) verbal; 2) gestural; 3) modeling; and 4) physical. These could be individualized as appropriate. In addition, when appropriate, an additional stimulus prompt might be added to increase the likelihood of a correct response.
l. Consider that a discriminative stimulus can be an instruction ("Patrick, it is time to brush your teeth") or an antecedent stimulus (e.g., the toothpaste and toothbrush on the bathroom sink). Both need to be very clearly described and specific relative to the desired response. It is also helpful when these antecedent stimuli naturally occur in the environment. In addition, when targeting a specific step within a task analysis, consider that the prior step is the discriminative stimulus. So, an additional instruction or verbal prompt introduced just prior to this step is unnecessary and perhaps counterproductive.
m. When appropriate, prescribe more frequent teaching opportunities for skill acquisition programs. The more opportunities to perform the skill and receive reinforcement (or corrective feedback and reinforcement), the more likely a skill will be acquired. Frequency of implementation should be daily or multiple times per week. Exceptions might include skills that individuals perform in community-based settings, which might be difficult to access on a daily schedule.
n. Standardize the error correction procedures across all skill acquisition plans, when appropriate. Staff instructions should include specification on the method of prompting (most-to-least or least-to-most), determination of the initial prompt level, description of how/when staff provide a prompted trial, and procedures for reinforcement following a prompted correct response.
o. Ensure differential reinforcement when implementing skill acquisition plans. Highly preferred reinforcers should immediately consequent correct responding following an instruction or discriminative stimulus. Reinforcers (perhaps less preferred reinforcers) should also immediately consequent correct responding following a prompted trial. Reinforcers should not follow incorrect responding. These differences in provision of reinforcement should be made obvious and easy for staff to implement.
p. Reinforcement procedures must be part of every skill acquisition plan and reinforcers should be individualized. Reinforcers should be broadened to include more than "verbal praise". If preferences are identified in the PFW, PFA, and/or PSP, they should be considered for inclusion as reinforcers within skill plans. Preference assessments should be regularly completed with all individuals and the results should be conspicuously noted in skill acquisition plans, PBSPs, etc.
q. In addition to forward chaining, utilizing backward chaining as well as total task presentation should be used, when appropriate. The selection of teaching methodology, obviously, will depend on individual skill level as well as the complexity of the program. Total task is often recommended for tasks that are not too long or too complex. In addition, forward and backward chaining are often recommended for individuals with more limited abilities.
r. Experiment (in a few cases) with skill acquisition data sheets that are completed during each learning trial. The current weekly data collection system (found in the majority of plans) might not be responsive enough for individuals who proceed quickly through a task analysis.
s. Ensure that the prescription of teaching session as well as the description of the data collection system is accurate, especially when data is not collected each trial. Perhaps utilizing the term "teaching trials" when indicating when the program should be implemented and "data collection" or "testing trial" when recording performance.

2. If not already in place, CCSSLC should provide procedures and guidance to PSTs in prioritizing skill acquisition programs and determining how individual preferences and/or needs are addressed or integrated within these plans.
3. Within the PSP document, teams should describe how the PST identified (or ranked) which needs or recommendations would be addressed through skill acquisition programming. This should include providing a rationale for differentiating between those needs addressed through the new skill acquisition plan format or the previous SSOs, if these types of plans remain in effect.
4. CCSSLC should continue to regularly estimate engagement across all residential, vocational and day program settings. The engagement data should be summarized by month at each setting and displayed in tabular or graphic format to assist with interpretation. When necessary, team

meetings should be implemented to address engagement scores that are below the acceptable criterion.

5. Plans should continue to implement a grid to monitor the last date of completed assessments (e.g., PALS, PFA, ICAP, etc.) typically utilized within the PSP process. Such a grid would facilitate efficient monitoring of required and/or optional assessments as well as help ensure their timely completion. In addition, this grid would support both internal (QE) and external (Monitoring Teams) review of the PSP process.
6. Efforts should continue to expand meaningful day and vocational programs.
7. The PSTs of individuals currently not attending a day or vocational program away from their residential unit should identify the barriers to their participation. As previously stated, unless there is clinical justification for an individual remaining on the unit, individuals should attend off-unit day and vocational programs. PSTs should develop individualized strategies in an effort to ameliorate the identified barriers.
8. For individuals identified as not being able to participate in off-site day programming, the medical reasons prohibiting their involvement should be identified clearly and justification provided in their PSPs. Plans also should be developed to assist, as appropriate, individuals in overcoming such obstacles. PSTs should review such reasons and justifications regularly, as well as progress made in assisting individuals to overcome such obstacles.
9. Data should be collected across all residential programs to track the nature of refusals to attend day or vocational programs. This data should include information on frequency and duration of refusals per individual within each residence. This data should be analyzed regularly to identify and address any issues that require attention.
10. The issues of work attendance and work refusal should be reviewed from a systems perspective by developing a collaborative approach across individuals' teams, but also across administration and disciplines to ensure that meaningful day program and vocational opportunities are provided to individuals that incorporate their preferences and strengths.
11. The pilot should continue of the new "5-minute engagement assessment," and consideration should be given to collecting, summarizing and reviewing feedback from individuals utilizing this new assessment method.
12. The vocational assessment pilot should continue, but with a focus on developing a vocational profile based on objective data, situational assessments, and/or a thorough work history, or interest inventory. Assessments should result in information and recommendations that assist teams in considering a full array of vocational options that would lead a person toward their vocational vision, and developing action plans to assist the individual in reaching that vision.
13. Performance on skill acquisition programs should continue to be graphed. As previously recommended, generally accepted graphing conventions should continue to be used (see recommendations with regard to Section K).
14. Efforts should continue to utilize and revise the new skill acquisition format, including the continued peer review as part of the Skill Acquisition Plan Review Committee.
15. Efforts should continue to integrate or complete skill acquisition programs in day program or vocational settings.
16. An acceptable methodology of preference assessments should be identified and conducted them for each individual served at CCSSLC in an attempt to identify more individualized reinforcers.
17. There should be continued emphasis on the importance of community-based skill acquisition programs. Efforts should continue in supporting such activities either individually or with small groups of individuals and staff, and in a normalized fashion.
18. Community outing data should continue to be collected and summarized. This should include more descriptive information regarding the community outings per week (or month) for each residence. In addition to tracking the number of outings for each individual, consideration should be given to providing descriptive statistics (range, mean, median, and/or mode) for each residence to assist with interpretation of the data. In some cases where the range is very large, the median and mode would be very helpful in understanding the nature of community outings for that residence. In addition, this data should be displayed monthly and continuously (over time) to allow trend analysis across months and years.
19. In addition to continuing to encourage a high level of community integration, efforts should be made to increase the diversity of community outings for residential programs (i.e., in particular Apartment 503, Apartment 515, and Apartment 516). Although medical appointments within the community are part of everyone's lives, it is unusual that they make up over 50% or more of someone's monthly outings.

20. Summary data should be developed with regard to the number of individuals currently employed on and off campus. This should include conspicuous data on changes of total numbers of individuals and/or total numbers of hours worked per program over time.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Community Placement Report for period between 1/1/10 and 12/31/10, dated 1/6/11; o List of Individuals Assessed for Placement between 11/1/09 and 11/16/10, dated 11/22/10; o List of Individuals Referred for Community Placement, dated 11/30/10; o List of Individuals with Discharge Planning between 7/12/10 and 11/16/10, dated 11/18/10; o List of individuals who have requested community placement, but have not been referred, dated 11/17/10; o List of individuals who have not been referred for placement solely due to LAR preference, dated 11/17/10; o Obstacles Identified for Individuals' Movement, dated 11/19/10; o List of Individuals Transferred to Community Settings, between 7/12/10 and 11/16/10; o Statement that no individuals have returned from a community residential placement from July 2010 to the present, not dated; o Statement that no individuals have been discharged with Alternate Discharge between 7/12/10 and 11/16/10; o List of Alleged Offenders between 7/12/10 and 11/16/10, dated 11/18/10; o CCSSLC Section T Policy Statement, including the following related procedures: ▪ T: CCSSLC Most Integrated Setting Policy (State Office Policy Number 018), dated 3/31/10; ▪ T.1: Most Integrated Setting and the Community Living Process, dated 12/8/10; ▪ T.2: Training Staff on Most Integrated Setting, revised 12/8/10; ▪ T.3: Informing Individuals of Alternate Community Placement Options, revised 12/8/10; ▪ T.4: Facilitating Community Placement from a State Center, revised 12/8/10; ▪ T.5: Lack of Consensus by the PST Regarding a Referral for Movement to a Community Setting, revised 12/8/10; ▪ T.6: Identifying Needed Supports and Services to Ensure Successful Transition in the New Living Environment, revised 12/8/10; ▪ T.7: Ensuring Comprehensive Assessment of Needs and Supports, revised 12/8/10; ▪ T.8: Evaluating Policies, Procedures, and Practices Related to the Transition/Discharge Processes, revised 12/8/10; ▪ T.9: Identifying Obstacles for Movement to a More Integrated Setting, revised 12/8/10; and ▪ T.10: Post Move Monitoring and Reporting, revised 12/8/10;

	o FY 2010 Joint Mental Retardation Authority (MRA) Presentation for Corpus Christi State School, dated 12/8/10; o Position Descriptions for: ▪ Admission/Placement Coordinator; ▪ Placement Coordinator; and ▪ Post Move Monitor; o Presentation Book for Section T; o Handouts from Personal Support Team Training on Community Living Options Information Process (CLOIP)/Referral Policies, on 1/4/11; o QMRP Training materials on new Community Living Discharge Plan (CLDP) process and sign-in sheet, dated 11/10/10; o Exhibit C from DADS Policy #018.1: Living Options Discussion Record, dated 3/31/10; o List of Training/Educational Opportunities for Past 12 Months, undated; o Nursing Discharge Summary, dated 8/1/10; o Form used to complete process for an alternate discharge; o Personal Support Plans (PSPs), Sign-in Sheets, Assessments, Personal Support Plan Addenda (PSPAs), Personal Focus Assessments (PFAs), Positive Adaptive Living Skills Assessments (PALS), any staff training on PSPs, and any monthly and/or quarterly reviews for the following: Individual #4, Individual #313, Individual #329, Individual #286, Individual #327, Individual #251, Individual #190, Individual #246, Individual #377, Individual #62, Individual #307, Individual #25, Individual #36, and Individual #101; o Completed audit/monitoring forms for last two month period for Section T, resulting in a total of nine completed audit forms; o Community Living Discharge Plans (CLDPs), including individuals' most recent PSP and related assessments for Individual #185, Individual #27, Individual #66, and Individual #344; o Working draft of CLDP for Individual #133 utilizing new format; and o Pre-Move and Post-Move Monitoring documentation for the following: Individual #27, Individual #66, Individual #84, Individual #185, Individual #258, Individual #344, Individual #11, and Individual #108. ▪ **Interviews with**: o Dora Flores, Admissions/Placement Coordinator (APC); o Sandra Vera, Post-Move Monitor (PMM); o Yvonne Recio, Placement Coordinator; o Rachel Rodriguez, QMRP Coordinator; and o Bruce Boswell, Programs Director. ▪ **Observations of**: o Personal Support Team Training on Community Living Options Information Process (CLOIP)/Referral Policies, on 1/4/11; and o Post-Move Monitoring visits for Individual #27, Individual #185, and Individual #344.

	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section T of the Settlement Agreement, the Facility found that it remained out of compliance with the majority of the indicators. However, it was not clear that the conclusions drawn were based on objective data. For the few sub-provisions of Section T for which the Facility found it was in compliance, these findings were consistent in zero out of three (0%) cases with the findings of the Monitoring Team. When addressing Section T.1.f of the Settlement Agreement that requires the Facility to conduct quality assurance activities to ensure compliance with this section, the Facility indicated that as of 12/15/10: "Six monitoring tools have been completed for Section T. Data shows that the facility is 30% in compliance with the provisions of Section T based on the monitoring tools." This provided an overall compliance rating for all of Section T, but it was unclear how this figure was derived. The review tools submitted were not weighted, and did not appear to be designed to provide an overall compliance score. As also is discussed with regard to Section T.1.f, a number of concerns were noted with regard to the auditing the Facility had completed, including a lack of defined methodology and instructions on the use of the audit forms, questions regarding whether the quality of the supports provided was evaluated versus the mere presence of documentation, and multiple reviewers conducting audits without establishment of inter-rater reliability. Moreover, as is illustrated below with regard to the provisions for which the Facility found itself to be in compliance, the Facility did not provide specific data from the reviews that were conducted to support its findings of compliance or noncompliance ratings for the various provisions of Section T. The Facility's POI indicated compliance with some of the indicators within Section T, including: ▪ Provision T.1.e that requires the Facility to verify 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 SSLC." The POI provided a narrative description of the steps that had been taken to achieve this, including the Post Move Monitor taking on this responsibility in September 2010, and efforts being made to define the essential supports in the CLDPs. For this indicator, the POI did not indicate that an audit or self-assessment had been completed of a sample of records to ensure that the reviews were being conducted in a timely manner, or that the quality of the pre-move reviews was sufficient. If such a review was conducted, as part of the overall review described with regard to Section T.1.f of the Settlement Agreement, then the specific findings should have been included in the section of the POI that discussed this provision. The Monitoring Team found the Facility in noncompliance with this provision, because it not only addresses the pre-move confirmation of essential supports, but requires that CLDPs include adequate descriptions of essential and non-essential supports. The Facility had made substantial progress in monitoring to ensure essential supports were in place prior to the individual moving, but CLDPs did not include all of the essential and non-essential supports to ensure safe and adequate transitions of individuals to the community. ▪ Provision T.2 that requires the Facility to use a standardized form to conduct post-move monitoring visits at seven, 45, and 90-day intervals to confirm that the essential and non-essential protections, supports, and services are in place, and if deficiencies are found, to make best efforts to ensure the needed supports are provided. In addition to providing a narrative description of a number of important steps that were taken to implement this provision, the Facility listed the initials of individuals who had

	transitioned and the dates on which post-move monitoring activities had occurred. As part of a complete self-assessment process, these dates should have been analyzed and a summary provided to determine the timeliness in meeting the seven, 45, and 90-day intervals, and a sample of post-move monitoring forms should have been reviewed to determine the quality of the monitoring completed, and if adequate action had been taken to address any deficiencies noted. The results of this review should have been summarized in the POI. The Facility's findings were not consistent with that of the Monitoring Team's review, which found issues related to the quality of the post-move monitoring reviews and the follow-up activities when deficiencies were noted. As is recommended with regard to Section T.1.f, the Facility should continue to expand its self-assessment activities in this area, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate the monitoring tools, particularly to separate out the different types of reviews to be completed using different methodologies and samples; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring on the review tools and their implementation; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.
	Summary of Monitor's Assessment: Individuals' PSPs continued to not consistently identify all of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation. It is essential, as teams plan for individuals to move to community settings, that PSPs provide a comprehensive description of individuals' preferences and strengths as well as their needs for protections, supports, and services. At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether or not community placement was appropriate. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. CCSSLC was at the initial stages of implementing the new Community Living Discharge Plan process. Overall, the revised form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. CCSSLC was at the initial stages of implementing these new processes. As a result, many of the documents reviewed for individuals who had transitioned to the community did not reflect these new expectations.

	The CLDPs reviewed generally were dated only a few weeks prior to individuals' transitions, making adequate planning difficult. They included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, CCSSLC had begun using the new checklist format, which generally was an improvement over the older version. It added a description of the evidence to be reviewed, and provided space for comments. The Post Move Monitor's comments often provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). However, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals. The post-move monitoring identified some issues with regard to the provision of services at the community sites. Not all of these items were addressed thoroughly with provider agencies.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR,	As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy.	Noncompliance

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	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.	With regard to the availability for funding community transition of individuals from CCSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. One issue that appeared to delay individuals' referral to the community at times was a Mental Retardation Authority (MRA) representative not being at a meeting at which the team decided a referral should be made. Based on the most recent Community Placement Report, two individuals were awaiting referral to the community due to the MRA not being present at their annual PSP meeting. More specifically: ▪ At the time of the Monitoring Team's onsite review, it had been approximately six weeks since Individual #62's PSP meeting was held at which the team had recommended a referral to the community. Based on review of his PSP sign-in sheet, the contract MRA had been present at the meeting, but not the designated MRA. There was no indication in the PSP that another meeting would be scheduled at which all necessary participants were present. ▪ Individual #255's PSP meeting had been held a month before the Monitoring Team's onsite review. At that time, he remained on the list of individuals whose referral to the community was pending a meeting at which the MRA representative was present. When the reason for a referral not being made is due to the lack of an MRA representative's presence at a meeting, all efforts should be made to schedule a meeting as soon as possible at which all necessary participants are present. At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether or not community placement was appropriate. Although PSPs included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations. For example: ▪ The team did not make any independent recommendation in the case of Individual #36. The PSP on page 3 indicated: "The PST determined the most integrated setting at the current time is: [Individual #36's] Guardian would like [Individual #36] to remain at his current home. He has no expectations for [Individual #36] moving out into the community due to his current medical conditions. He wants [Individual #36] to continue residing at the CCSSLC where all of his needs are being met." ▪ For Individual #246, the team did not make an independent recommendation. The PSP stated: "The PST determined the most integrated setting at the current	

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		time is: The PST will respect [the guardian's] recommendations due to [Individual #246's] behavior. [Individual #246] will be recommendation (sic) to take group home tours to understand the variety of options that are available to him." Of note, no action plan was included in the PSP for Individual #246 to complete tours of group homes. ▪ Individual #251's team indicated that there were no barriers to her transition to a community setting. However, the team concluded that: "At the current time the PST the less restrictive environment for [Individual #251] is remaining at CCSSLC (sic). Although during the meeting she kept going back and forth on whether she would like to move to a group home or remaining living at CCSSLC the PST will support any decision [Individual #251] makes." No independent recommendation was offered, and no specific educational opportunities were identified to assist Individual #251 in making an informed decision. The professional teams supporting individuals at CCSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.	
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:	Since the last review, the Facility had developed and begun implementation of policies related to Section T of the Settlement Agreement. The Facility had adopted, in full, the State Office Policy entitled Most Integrated Setting Practices, Policy Number 018.1, dated 3/31/10. In addition, the Facility had broken the policy down into subsections, including: ▪ T.1: Most Integrated Setting and the Community Living Process, dated 12/8/10; ▪ T.2: Training Staff on Most Integrated Setting, revised 12/8/10; ▪ T.3: Informing Individuals of Alternate Community Placement Options, revised 12/8/10; ▪ T.4: Facilitating Community Placement from a State Center, revised 12/8/10; ▪ T.5: Lack of Consensus by the PST Regarding a Referral for Movement to a Community Setting, revised 12/8/10; ▪ T.6: Identifying Needed Supports and Services to Ensure Successful Transition in the New Living Environment, revised 12/8/10; ▪ T.7: Ensuring Comprehensive Assessment of Needs and Supports, revised 12/8/10; ▪ T.8: Evaluating Policies, Procedures, and Practices Related to the Transition/Discharge Processes, revised 12/8/10; ▪ T.9: Identifying Obstacles for Movement to a More Integrated Setting, revised	Noncompliance

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		12/8/10; and ▪ T.10: Post Move Monitoring and Reporting, revised 12/8/10. The subsections generally were reiterations of the State Office Policy. Staff reported that breaking the larger policy down into smaller section had been done to facilitate staff training. Concerns related to the policies included the following: 1) at times, additional detail was needed to describe how the Facility was going to implement the State policy; and 2) reportedly, the State policy was under revision, but the current State policy and corresponding Facility policies/procedures did not accurately reflect some of the positive changes that had begun to be made with regard to practice. The following provide examples of some of the concerns noted: ▪ The policy/procedure entitled Training Staff on Most Integrated setting, dated 12/8/10, indicated that at CCSSLC the Admissions Department would complete training on this policy section. It made the general statement that: "The training will be provided to all applicable disciplines and all PSTs." However, it did not provide any additional Facility-specific information, such as which staff would complete what type/level of training, timeframes for staff completing training (e.g., as part of orientation training, within so many weeks/months of hire, etc.), what the specific topics the training would include, and/or how mastery of the information would be evaluated (i.e., competency evaluation methods). ▪ The Facility had decided to complete pre-move monitoring visits to ensure that essential supports were in place prior to an individual's transition. A specific format for the reviews was being used. This process or related expectations were not documented in the policy/procedure entitled Ensuring Current Comprehensive Assessment of Needs and Supports Prior to Individual's Movement, dated 12/8/10. Rather, the written policy described a process in which the Facility was relying on the Mental Retardation Authority to complete this process. ▪ During the training the Monitoring Team observed, it was clear that expectations had been set at the Facility regarding significant involvement of individuals' teams in activities related to, for example, visiting proposed homes and day/vocational sites in the community, training community provider staff on key elements of individuals' plans prior to the individual conducting overnight visits, and meeting to discuss options after individuals had conducted pre-selection visits. These expectations were not clearly set forth in the policies/ procedures. ▪ The post move monitoring process had been modified in practice to involve individuals' teams meeting after each monitoring report was completed to review the information, and determine if any action needed to be taken. This process was not yet included as part of the written policy/procedures. ▪ Likewise, it appeared that monitoring was occurring at the various settings in which supports were being provided. However, neither the State Office policy or	

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		the Facility policy had been modified to specifically require that reviews be completed at each site at which essential and/or non-essential protections, supports, and services were being provided for each of the required monitoring visits. Action Plan #6, included in the Facility's POI, appeared to have been designed to address a related recommendation from the Monitoring Team's previous reports. Although the action plan report indicated that policy had been modified to address this concern, review of the revised Facility policies did not confirm that necessary changes had been made. It will be important for State policy as well as Facility policy to be modified to reflect changes in procedure so that expectations regarding practice are clearly delineated. In addition, as appropriate, the Facility should include in its local policies any Facility-specific details that are relevant to full implementation of the State policy. The Facility had made progress in this area by adopting the State Office policy and incorporating it into the Facility policy manual. In addition to concerns noted above with regard to the policies and procedures, the Facility remained out of compliance with the implementation of many of these policies. This is discussed below with regard to each of the subsections of provision T.1.b of the Settlement Agreement. As a result, an overall finding of noncompliance has been made for Section T.1.b.	
	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.	As noted above with regard to Section F of the SA, CCSSLC had begun to use the new format for PSPs. The new format included a section entitled the "Optimistic Living Vision for…" This section included discussion regarding the individual's and his/her LAR's awareness of community options, their preferences for a specific living option, obstacles identified by the PST, and the supports and services the individual needed in various areas. A review was conducted of a sample of 14 PSPs that had been completed using the new format. The findings related to this review are discussed below with regard to the two requirements included in this provision, including: 1) the identification in the PSP of 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; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles. <u>Identification in PSPs of Needed Protections, Services, and Supports</u> As was discussed with regard to Section F of the Settlement Agreement individuals' PSPs did not consistently identify all of the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation. Some of these issues related to thorough and adequate assessments not being completed (e.g., nursing, psychiatry, physical and nutritional management, and communication), services and	Noncompliance

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		supports not being adequately integrated with one another (e.g., psychology and psychiatry, and psychology and dental/medical), and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychiatry, psychology and habilitation, physical and nutritional supports, and communication). It is essential, as teams plan for individuals to move to community settings, that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by CCSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move, and non-essential supports are provided in a timely and complete manner. If all of the necessary protections, supports, and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition. Review of 14 of the PSPs that were developed using the new format and processes showed some progress in teams more effectively identifying individuals' specific needs for supports and services. However, none of the plans reviewed (0%) included a comprehensive list of the protections, supports, and services needed to support the individual. Often this appeared to be due to staff's assumptions that supports were being provided at the SSLC, and that they did not need to be spelled out in detail. In other instances, the continuing deficits in assessments from various disciplines appeared to stymie the teams' ability to create a comprehensive list. In other instances, the lack of integration across disciplines and lack of incorporation of the various plans (e.g. BSPs, PNMTs, health care plans, psychiatric treatment plans, communication plans, etc.) continued to result in incomplete PSPs. The following provide examples of some of the concerns noted in the plans reviewed: ▪ Individual #101's PSP provided a list of supports and services she required. Some of these supports were written in measurable terms, and provided a clear picture of the supports that would need to be provided to Individual #101 no matter where she lived. For example, a lengthy list of adaptive equipment was provided, and details such as a requirement that two staff be available to assist	

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		her with bathing were included. However, in listing her needed supports and services, it appeared that the team had made a number of assumptions based on her current living environment. For example: o Under "Physical environment (home)," the team indicated: "All of [Individual #101's] needs are currently being met in her home. She receives nursing care for g-tube feedings and medication passes. She has all adaptive equipment needed for her care." This did not adequately describe the physical environment she needed, which appeared to include an accessible home that was able to accommodate a large wheelchair and several pieces of adaptive equipment. o Under "Employment/Day Programs/Schools," the team indicated: "[Individual #101] is not employed. She does attend day programming in the morning and the afternoon. [Individual #101] is asleep most of the time." This did not provide a description of the type of day program she required, the supports and services that needed to be available at the day program (e.g.. nursing, the staffing ratio, etc.), or the activities that should be made available to Individual #101 during day programming. Overall, Individual #101's PSP did not illustrate the level of integration needed to adequately describe the supports that would need to be available in any setting in which she lived. For example, there were a number of nursing care plans being implemented related to, for example, a gastrostomy tube, constipation, a dislocated shoulder, hypothermia, and seizures. All of these were listed as the responsibility of the "RN/QMRP." There was no description of how direct support professionals and LVNs needed to support Individual #101 in relation to these conditions. Similarly, Individual #101 had a PNMP that included, amongst other requirements for her care, a positioning program, and instructions for safe handling and transfers. The action plan addressing the PNMP only listed OT/PT/SLP as responsible. There was no description of direct support professionals' responsibility with regard to the implementation or documentation of the PNMP, nor was there any indication regarding the competency-based training that staff would need to complete to implement the program. Moreover, there was no indication of how the PNMP would be integrated into Individual #101's day, or what functional outcomes were expected to be achieved. ▪ Individual #36's team described him as having a number of medical complexities, requiring 24-hour nursing support, and assistance in all areas of daily living. However, the specific protections, supports, and services that Individual #36 needed to be provided were not identified in measurable ways in his PSP. For example, none of the medical supports Individual #36 needed were included in action plans in the PSP. The health care plans being implemented by	

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		nursing were referenced in action plans, but the specific supports and services nursing, as well as direct support staff, were implementing to maintain his health were not specifically identified in the PSP. Individual #36's LAR was not interested in discussing transition to the community, and had indicated that it would be difficult to identify a community home that could meet his medical needs. Without having a full list of the protections, supports, and services Individual #36 required, it would be difficult to determine if a community program existed that could meet his needs or not. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> As noted above, the new format for the PSP included a section on obstacles identified by the PST. In reviewing the sample of 14 PSPs that utilized the new format, it appeared that some obstacles were identified. It often was unclear if: 1) the lists of obstacles were based on the team's knowledge of what was or was not available in the community, because often they were written in terms of the needs of the individual as opposed to lack of availability of such supports in the community; and 2) if the lists were complete. Of the 14 PSPs reviewed, 13 should have had obstacles defined. The remaining individual had been referred for placement in the community. Of the 13 remaining plans, none (0%) included an adequate list of obstacles. Of these 13 plans, nine had information included in the obstacles section, but this information was generally a description of individuals' needs as opposed to the obstacle preventing community transition. Moreover, action plans to overcome the obstacles identified generally were not present. Of the 14 PSPs, one (7%) included an action plan to overcome obstacles identified. Even when a plan was present, it was not adequately individualized. For example, the one plan found for Individual #313 stated that information would be provided to her guardian about community options. This was not individualized to address her guardian's specific concerns about community transition. Based on interviews, Facility staff recognized that this was an area that continued to need improvement. The following provides some examples of concerns noted with regard to the identification of obstacles and plans to overcome obstacles to individuals' transition to the most integrated setting appropriate to their needs: ▪ For Individual #101, the obstacles listed included the following: "[Individual #101] would need a wheelchair van for transportation. She would also need a home that could accommodate large wheelchairs. A home with a bathing trolley, nursing care for g-tube feedings and medication passes. She would need a home with a mechanical lift." These obstacles were written in terms of Individual #101's needs. It was not clear from the narrative if the team had determined whether or not such supports existed in the community. If they did	

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		not, the team had not developed an action plan(s) to overcome the obstacles identified. ▪ Similarly, Individual #25's PSP identified the following as obstacles: "[Individual #25] is nonverbal and staff stated that [Individual #25] is blind. [Individual #25] needs assistance with all of his daily living activities. [Individual #25] has several medical issues that require 24 hour (sic) nursing, he has a G-tube for feeding. Transportation is another obstacle since [Individual #25] cannot utilize Care B bus services. Transportation to his off campus medical appointments are done by a campus transporter accompanied by DCPs who work with [Individual #25]." None of the items the team listed are automatically obstacles to community transition. It was unclear if Individual #25's team was aware that alternatives to the public transportation system would be available to individuals supported by community providers, and/or that many individuals who are blind and/or require assistance with daily livings skills live successfully in the community. Likewise, it was unclear if the team had researched whether 24-hour nursing that would meet Individual #25's needs was available. No plan to overcome the listed barriers was included in the PSP. ▪ Individual #307's PSP included only the following obstacle to transition to the community: "DCP [name] expects that [Individual #307's] PICA tendencies can be addressed should she be able to move to the community." The team concluded, though, that: "The team is in agreement that [Individual #307's] current home is the optimal living option for [Individual #307] at this time." No plans to overcome any perceived obstacles were included in the plan. ▪ Individual #246's PSP listed the following as the obstacles to transition to the community: "His obstacles include aggression. He becomes frustrated easily and will damage property that is accessible to him. He becomes infuriate (sic) when his needs are not met. His needs being that he becomes dissatisfied with his daily living and becomes agitated and frustrated and wants to move to another unit." This was a list of Individual #246's behavioral issues as opposed to supports that he required in a community setting that the team had determined were unavailable. The team had offered no specific plans to overcome the obstacles that it had identified. ▪ It appeared that Individual #251's difficulty in making a decision regarding whether or not she wanted to transition to a community setting was the only concern her team had with regard to making a referral. However, this was not specifically identified in the PSP as an obstacle, and it did not appear that the team had attempted to identify Individual #251's specific concerns. No action plan was developed to address Individual #251's reluctance. CCSSLC remained at the beginning stages of identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition	

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		to PSPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement.	
	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.	As described in previous reports, CCSSLC has engaged in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. Based on documentation provided, this had taken a number of forms, including: ▪ On 8/31/10, CCSSLC hosted a Community Living Expo Fair. On October 27, 2010, the Admissions and Placement Department hosted a Home and Community-Based Services HCS provider fair. The providers represented offered services in a variety of counties. ▪ Visits to community group homes and day programs continued to occur every Friday with assistance from the Active Treatment Department and Nueces County Mental Health Mental Retardation (MHMR) Authority. These were open to individuals, families/guardians, or staff who wanted to attend. Such visits offered individuals and their families the opportunity to obtain first-hand knowledge of what community supports are available, to meet provider staff, and potentially other people with whom they could have the opportunity to live or work. ▪ Individuals and their guardians also were provided information through the Mental Retardation Authority Community Living Options Information Plan process. This occurred regularly as part of the individual planning process. ▪ On 12/8/10, Facility Staff, along with MRA staff from Nueces County and Coastal Plains, made a presentation to which staff as well as family members and individuals were invited. The topic areas covered included eligibility for services, and descriptions of the types of services available, including Home and Community-Based Services (HCS), ICFs/MR, and State Supported Living Centers. Permanency Planning also was discussed. ▪ The Facility continued to host Family Association meetings, for example, on 9/11/10, and 12/11/10, at which a variety of topics were discussed. ▪ Other training options offered by the Facility included: o On 4/27/10, State Supported Living Policy: Most Integrated Setting, and Community Referral Process; and o On 11/10/10, Facility Policy Section T, Revised CLDP, Revised Post Move Monitor (PMM) Checklist, and Community Referral Process. ▪ As indicated in previous reports, CCSSLC was fortunate to have a number of staff, including the Admissions/Placement Coordinator and Post-Move Monitor, who had experience working in the community system. This allowed the APC, for example, to assist in answering questions about the community that individuals, families/LARs, or other staff might have.	Noncompliance

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		The most challenging area with regard to education of individuals and families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. The Optimistic Living Vision section of the 14 PSPs reviewed often mentioned exposing an individual and/or his/her guardian further to community options, but the plans to overcome the obstacles identified in this area often were not present or adequately individualized. Of the 13 PSPs reviewed for individuals who were not referred for transition to the community, five (38%) identified a need for further education (Individual #101, Individual #307, Individual #377, Individual #246, and Individual #313), but only one included a written action plan (Individual #313), and this one was not an adequately individualized plan to address the needs identified with regard to the education of individual and/or the LARs/primary correspondent regarding community options. The following provide examples of some of the concerns identified: ▪ The narrative section of Individual #101's PSP noted that: "[Individual #101] is not familiar with alternative living environments since she has resided at the State Supported Living Center most of her life. [Individual #101] will be provided opportunities to visit various places in the community." There was no action plan that specifically addressed education about community living options. There was a general staff service objective (SSO) that read: "Staff will take [Individual #101] off campus to participate in activities." ▪ Individual #251's team concluded that a referral would not be made because "Although during the meeting she kept going back and forth on whether she would like to move to a group home or remaining living at CCSSLC the PST will support any decision [Individual #251] makes." Individual #251 had stated at one point during the meeting that she did not want to visit a group home. No action plan was included to either determine what her specific concerns were regarding transition to the community, or provide her additional education about options. For example, the team should have considered having Individual #251 talk to a peer who had visited homes in the community or had already transitioned to the community. As opposed to conducting formal visits to group homes with the MRA, the team should have considered a visit to the home of a friend or peer who was successfully living in the community. Pictures of various community options could have been a part of a purposeful educational plan for Individual #251, as could helping her to develop a list of questions for community providers and asking these questions during a provider fair on campus. Based on the documentation included in the PSP, the team had not considered any creative options in assisting Individual #251 to make an informed decision about living options. The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of	

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		various individuals and guardians. For example, as individuals successfully transition to community settings, with their and their guardians' permission, newsletter articles could highlight such success stories. At times, it might be helpful to match individuals and/or guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This allows someone with first-hand knowledge about the process, including the challenges as well as the successes, to share information and provide support. Although the Facility was continuing to complete some of the basic activities related to education, little progress had been made since the last review in individualizing the process.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The Monitoring Team requested, as part of its document request for the past 12 months, a list of individuals who had been assessed for placement, the date of the assessment, and resulting recommendations. The list provided appeared to be a list of all individuals who had had an annual PSP meeting between 11/1/09 and 11/16/10. The list included 286 individuals. Eight of these individuals had been referred by their teams for transition to the community, nine had been identified as appropriate to move to another SSLC, two had been identified to move to another home on campus, and one to move out of state. As is discussed above with regard to Section T.1.a of the SA, the individuals' PSPs reviewed did not document an independent assessment by the professionals on the team of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs. The Facility's POI documented that compliance had not been achieved, but indicated that this assessment was done every year as part of each individual's annual PSP process. The State should provide the Facility with guidance regarding the process to be used for assessing individuals for placement/transition to the most integrated setting appropriate to meet the individuals' needs.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	CCSSLC was at the initial stages of implementing the new Community Living Discharge Plan process. The Admissions Placement Coordinator, Placement Coordinator, and Post Move Monitor had completed training with the State Office on the new process. On 11/10/10, the Placement Coordinator trained 13 of the 18 QMRPs on the new process. Additional training was in the process of being provided to PST members. During the week of the Monitoring Team's onsite review, a training session on the new CLDP process was held for members of the PSTs. The training session was an interactive one with PST members asking a number of questions, and providing input and suggestions based on their involvement with individuals who had or were transitioning to the community. Topics discussed included, but were not limited to, the teams' involvement with pre-selection visits, timeframes for completion of various activities, 45-day assessments, team reviews of individuals who had a referral pending for more than 180 days, addressing lack of consensus regarding referrals to the community, the process	Noncompliance

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		for rescinding referrals, and teams' involvement in the post-move monitoring process. The training provided was informative, and offered practical advice regarding the implementation of the revised process. Many of the changes to the CLDP format were in response to discussions that Monitoring Teams had with Facility and State staff during onsite monitoring visits, as well as in response to findings noted in baseline monitoring reports. The Monitoring Teams appreciate and acknowledge the Facility and State's responsiveness. Additional comments regarding the specific CLDPs reviewed are offered later in this section. The following comments are based upon a review of the blank template: ▪ Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. ▪ The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. This will provide an opportunity for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments are completed and reviewed, and following up after the individual has moved by reviewing the results of each post-move monitoring visit. ▪ The form included a section for documentation of key events, such as dates referral packages were sent to the MRA, dates potential provider lists were sent to the PST, dates the PST met to decide upon providers for pre-selection visits, information related to pre-selection visits, and results/deliberations of such visits. Because the CLDP is a document that would need to be updated at many stages of the process, it is recommended that dates be included each time the document is revised. For example, such dates could be added to the first page, or placed in a footer. ▪ A list of standard items to be completed and in place prior to every individual's move now appeared on page six (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus on identifying those essential and non-essential supports that were truly based upon individual needs and preferences. ▪ The list of summaries and recommendations on page nine was also an improvement. It was designed to help the PST remain focused on its primary task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or non-essential supports. ▪ Psychiatry should be added to the list of summaries and assessments.	

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		▪ Likewise, if the PNMT has conducted specific assessments, and/or made recommendations, these should be included. ▪ The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the Monitoring Team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or non-essential supports, if the PST believes that implementation of any of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the State's desire for transition to grow out of the PSP process. ▪ Many of the person directed planning questions included on pages 13 and 14 should assist teams in planning for individuals' transition to the community. It will be essential, as the process is implemented, to ensure that the information gathered from this component of the new process is incorporated into the essential and non-essential supports. ▪ It was also good to see that the CLDP required a description of the evidence to indicate whether or not an essential or non-essential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. ▪ The pre-move site review should also be sure to include the list of standard items on page six. This could be added to the list on page 23. ▪ Neither the pre-move nor post-move monitoring forms included a column in which to state definitively the findings (i.e., Yes, No, N/A). In reviewing completed forms, the narrative in the comments section had to be analyzed to determine if the monitor had found the items/activity to be present and/or completed. These forms should be revised to clearly indicate the presence of absence of an essential or non-essential protection, support, or service. Based on interviews with staff, some of the changes that were beginning to be seen for individuals supported by CCSSLC included: ▪ Beginning in July, a Placement Coordinator had been hired to work with teams throughout the process. An email had been sent to PSTs indicating that the Placement Coordinator should be invited to any PSPs at which it was believed a referral for community transition might be made. The Placement Coordinator was attending such meetings to assist teams in their discussions about supports and obstacles. For individuals who were referred, the Placement Coordinator would become involved in working with the MRA and the team to identify	

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		potential providers, set up site visits, attend team meetings at which potential providers were being discussed, and develop the CLDP. ▪ CLDPs were beginning to be developed at the time of referral. Reportedly, from the first meeting, essential and non-essential protections, supports, and services were being identified. As pre-selection visits were completed, teams were expected to be using this list to make sure that needed supports and services were available. ▪ Teams were becoming much more involved in the process. Expectations had been set that, depending on the needs of the individual, members of the PSTs would attend visits with the individual to assist the individual and LAR in selecting a provider and ensure the specific sites/programs would meet the individual's needs. ▪ Prior to overnight visits occurring, teams were expected to provide training to community provider staff on the implementation of the individual's programs and plans (e.g., BSPs, PNMPs, etc.). ▪ As team members were updating assessments, they were being asked to ensure that the recommendations included were transferable to the community. ▪ Teams were continuing to provide follow-up after the individual transitioned to the community. One example provided was in relation to Individual #66. After she transitioned to the community, she exhibited behavioral issues that resulted in community provider staff regularly calling the police. The CCSSLC team went out to meet with community provider staff. It was determined that the provider had another home in a different part of the State that would provide a more structured environment. Once the decision was made for Individual #66 to move to the other home, the CCSSLC team went to the new home to train the providers' staff at that location on her plans (e.g., BSP), and assist with the transition. At the time of the Monitoring Team's review, Individual #66 had adjusted well to the more structured environment. The CCSSLC team's continued involvement likely contributed to the positive outcome for this individual. ▪ Medical staff had begun to attend more of the CLDP meetings. This had proven helpful in clarifying questions that the community provider staff had regarding current and historical medical information. It appeared that the Medical Director was instrumental in ensuring that physicians were attending these meetings. ▪ As is discussed in further detail below, the Post Move Monitor was completing pre-move visits, usually on the same day that the teams were providing in-service training to community provider staff. This had improved the process being used to ensure that essential supports were in place prior to the individual transitioning to the community.	

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		These positive changes were in the initial stages of implementation. Based on interviews with staff, initially, there was some resistance on the part of some PSTs, but teams were beginning to see the benefits of the more extensive transition process and the more intensive involvement of the individuals' CCSSLC teams. During future visits, the Monitoring Team will continue to review the outcomes being attained for individuals as a result of the implementation of these new processes. At the time of the review, the new process/format of the CLDP had not been fully implemented for any of the individuals who had transitioned to the community, but portions of the new process had been used, such as the new pre-move monitoring format, and the revised post-move monitoring format. The new process was being used for any individuals who had been referred for community transition since 10/1/10. The Facility provided the Monitoring Team with a working draft of the CLDP being developed for an individual using the new process. Results of the review of these newer formats and processes are discussed in the sections that follow, as appropriate. During upcoming reviews, the Monitoring Team looks forward to assessing the full implementation of these new procedures. Community Living Discharge Plans were reviewed for four individuals. This sample was drawn from the list of seven individuals who had transitioned from the Facility to the community since the Monitoring Team's last onsite review, representing 57% of this group of individuals. These included the CLDPs plans for Individual #344, Individual #66, Individual #27, and Individual #185. In addition, the working draft of the CLDP for Individual #133 was provided as an example of an individual for whom the new CLDP process was being implemented from start to finish. With regard to the timeliness of the Community Living Discharge Plans, none of the four (0%) were developed sufficiently prior to the individual's transition, but were developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. For example: ▪ It appeared that the CLDP was developed for Individual #85 approximately 10 days before she moved. The CLDP was dated 9/21/10, and she moved on 10/1/10. ▪ Individual #344's CLDP was dated 12/13/10, and she transitioned on 12/29/10. As discussed above, it appeared that the revised CLDP processes were designed to address this issue. Expectations had been set for the CLDP process to begin at the time of referral. This was beginning to be seen at CCSSLC, for example, for Individual #133. The Facility was beginning to make progress in this area, but remained out of compliance.	
	1. Specify the actions that need	The Community Living Discharge Plans reviewed included a number of action steps	Noncompliance

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	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.	related to the transition of the individuals to the community. However, none of the four plans reviewed (0%) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition, and when such steps were identified, they often were not sufficiently detailed or measurable. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals. The following provide examples of some of the concerns noted, with regard to the CLDPs reviewed, with respect to defining the role of the Facility staff in the transition process: ▪ Individual #27's CLDP included some specific steps CCSSLC staff were to take to assist in the transition, such as ensuring he had two pairs of glasses, and providing current doctor's orders and a 30-day supply of medications. However, Individual #27's CLDP included an essential support that stated: "CCSSLC staff should in service [the community provider] staff on [Individual #27's] special needs: medications; treatments; PSP; likes/dislikes; diet and level of supervision (routine)." It did not define which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or what level of mastery of the information was required (e.g., demonstration of competence). It also did not specifically identify which PST members from CCSSLC would provide the training. It also did not specify the method of training, for example, if it would be necessary for community provider staff to shadow CCSSLC staff, and/or show competency in actually implementing a plan, such as a BSP. For some individuals, specific components of their PSPs should be targeted for more intensive training of community provider staff. The evidence for this component of Individual #27's plan was the sign-in sheets. In some instances, this will not be adequate, and actual demonstration of the skill by staff supporting the individual should be the evidence required. ▪ With regard to CCSSLC's involvement in Individual #185's transition, his CLDP was almost identical to Individual #27's plan. The training section did not provide the specificity needed. ▪ Although based on interview, Individual #344's team was involved in determining the appropriateness of potential homes and day programs to address issues related to her blindness, but her CLDP did not document these activities. Her CLDP did not include an action step to specifically ensure that Facility staff conducted the necessary assessments of potential sites. It should be noted that Individual #344's CLDP included some specific actions that Facility staff were to take. For example, staff were responsible for purchasing a radio for her, because this was identified as an item that would assist her to transition more comfortably to her new environments. This was an example of good	

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		incorporation of an individual's preferences into the transition process.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Based on the sample reviewed, teams generally identified target dates for the completion of actions steps included in CLDPs. However, teams did not consistently identify the specific person(s) responsible for action steps included in CLDPs for which Facility staff or others were responsible. Terms used to identify responsibility frequently were "[Community-Based Services] provider" or "CCSSLC PST." These were not sufficient to identify the specific staff responsible. For example, this was the case for Individual #185. For some individuals, names had begun to be added for the community provider staff and/or a title for CCSSLC staff (e.g., RN Case Manager). Individual #27's and Individual #344's plans included some of this more detailed information regarding assignments of staff. However, consistently for all four plans reviewed, additional delineation of which staff were responsible for completion of tasks was needed.	Noncompliance
	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.	Based on review of four CLDPs, three of the four (75%) included documentation that the plans had been reviewed with the individual and/or the LAR. For the plan for Individual #185, no sign-in sheet was provided.	Noncompliance
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.	Based on the documented dates of assessments reviewed at the CLDP meetings, it appeared that some assessments had been updated within 45 days, but others had not. For example: ▪ For Individual #66, updated assessments were not found for nutrition or OT/PT. ▪ For Individual #344, an updated assessment could not be found from the physician, or for vocational. ▪ Some assessments appeared to be completed after the transition occurred. For example, the dental update for Individual #27 was dated five days after the individual transitioned to the community. ▪ Others were not dated. For example, the psychological update for Individual #27 was not dated. Since the previous review, discharge summary formats had been developed by many disciplines that appeared to assist team member in summarizing relevant information, and reviewing and modifying recommendations. However, it was difficult to confirm that all of the relevant assessments had been updated. In order for this item to be in substantial compliance, some sort of checklist or tracking tool should be used that lists all required and optional (i.e., as needed depending upon the individual) assessments, so	Noncompliance

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		that PSTs and community providers can be assured that no relevant assessments are missing. In the Monitoring Team's previous report, it was recommended that, particularly with regard to the transition of medical and other clinical information, that a summary be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.) to facilitate the transition of this information to community medical care providers. During the most recent review, a nursing discharge summary was presented, and it was explained that this new format recently had been put into use. It was very similar to the nursing assessment forms that had been in use for general assessments of individuals at the Facility, and as noted with regard to Section M of the Settlement Agreement, had not produced adequate assessments. Although the form itself included the necessary sections and related "Summary" for each section, if nurses do not complete these sections correctly, the information provided will be inadequate. The Monitoring Team will review completed forms during upcoming reviews. One addition that should be made to the form is Axis I, II, and III diagnoses. In addition, similar summaries should be developed and implemented by medical and psychiatry staff. As discussed with regard to Section L.1, the content of the transition packet for medical information was reviewed for a number of individuals (Individual #27, Individual #344 Individual #121, Individual 185, Individual #66, Individual #84, and Individual #11). It was interesting to note that the contents were different for each of them. A standardized approach would be helpful. The date of the transition was not always clear, because the transition date listed in some documents preceded the date of the forms reviewed. These forms should focus on information that will guide the medical team in the community in following up on health care, and ensuring there is no confusion about current or future needs. Providing too much information, or information presented in a manner that is not user-friendly might not be effective, because staff have little time to sift through endless paper work. With this in mind, it was excellent that the volume of information was generally kept to a minimum. There were a few excellent documents that should be considered for every packet, including: current medications updated, current lab/diet/and treatments, a discharge medical assessment by the PCP, the last annual medical assessment and annual physical exam, a copy of the most recent lab and x-rays, a dental discharge summary, the most recent nutritional evaluation, and a discharge summary nursing assessment with complete vaccination list. Remote information, if relevant, should be typed on one of these documents as applicable (the annual medical assessment or annual nursing assessment). Handwritten entries should be minimized. It is also important to ensure there is a list of medications taken that day,	

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		and the medications that need to be provided through the transition day. A copy of the current MAR would be instructive to ensure no medication dose is missed. A list of actions pending (when the next eye appointment is due, the next lab test (specific test listed) is due, etc., would be helpful to ensure lab orders and referrals are not missed at the initial physician appointment. There also should be listed a telephone number and contact person at CCSSLC that the receiving medical office can call for additional information or clarification of information. It should be a specific person or designee assigned ahead of time who will have ready access to the individual's record. Additionally, the PCP should attend transition meetings for individuals with complex health issues, especially meetings specifically addressing transfer of health information. The PCP will begin to understand the health care system to which the individual is moving, and can answer specific questions and provide additional information in the dictated discharge assessment. Currently, the PCP/Medical Director attended at least some of the transition meetings. In summary, it was positive that discharge summary formats had been developed and were being used by some disciplines to update individuals' assessments within 45 days of their transition. However, there continued to be assessments that were not updated, or were updated after the individual transitioned to the community.	
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.	The CLDPs reviewed included essential and non-essential supports. However, as reported in the Monitoring Team's previous reports, it appeared that the Facility was at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This made it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transition to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways. In none of the four plans reviewed (0%) was a comprehensive set of essential and non-essential supports identified in measurable terms. The following provide examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ Individual #185's CLDP included as non-essential supports that his community provider offer him day habilitation supports, and assist him in completing an application with the Department of Assistive and Rehabilitative Services (DARS). The supports to be provided at his day habilitation program were not defined in any measurable way. The narrative section of his CLDP indicated that: "working is very important to [Individual #185]." It described his recent history of having	Noncompliance

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		a janitorial job off campus, but requiring too much need for redirection. Before transitioning to the community, he had returned to a job on campus and was cleaning hangers at the work center. Although the team discussed with the provider agency the possibility of their contracting with CCSSLC to allow him to continue his current job until another could be found, this was not written in as an essential or non-essential support. At the time of the Monitoring Team's review, Individual #185 was participating in a day habilitation program, where his aggressive behavior had begun to increase. The program did not offer work options, and staff described that his day was spent coloring. Although the community provider was actively seeking other options, including volunteer and work options, Individual #185 did not have access to what appeared to be both a preference of his, and a support need. It was unclear why identification of appropriate work or volunteer options were not included as an essential support. At a minimum, the CLDP should have set forth specific requirements regarding what activities would be provided in the day habilitation setting, and a deadline for identifying volunteer and/or competitive work. Although his CLDP identified the need for medical supports, not all of these were detailed in measurable terms. Some measurable supports included the need to identify a primary care physician within 30 days, an eye exam to be attended on a specific date, and for an EKG to be completed by a certain date, but others were not measurable. For example, the plan indicated that the provider would provide Individual #185 "with medical care as needed to ensure his good health to include monitoring of his active medical diagnosis of constipation… ensure that [Individual #185] receives services for Psychotropic Medication Review." The CLDP did not indicate, for example, if staff needed to monitor his constipation/bowel movement daily, or what process or notifications needed to be made if a problem was noted. No detail was provided with regard to the frequency of psychotropic medication reviews. Under "Safety," the team had listed "Letter to Court re: Commitment Status," and "Pre-Move Site Review. The completed Site Review Document will serve as evidence." None of the components of what would be required for a "safe" environment were listed. This individual had a history of involvement with the criminal justice system. Although the narrative section of the CLDP discussed this history, it was not clear that the team had included any specific supports to prevent recurrence of such issues in the future, except to indicate that all visits with family needed to be supervised by staff. While at CCSSLC, Individual #185 had a BSP. In the non-essential support section, his CLDP indicated that: "CCSSLC Psychologist recommended to [the	

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		community provider] that [Individual #185] continue his BSP, [and] his current psychotropic medications." If the team believed that this was necessary for his safe transition, then it should not have been a recommendation, but a requirement. In addition, the team had not defined what level of psychological services he required, for example, the frequency of involvement of a psychologist, and/or the qualifications and role of the psychologist. The team also did not define what would need to occur for changes to be made to the BSP, such as a functional assessment. It also was not clear why this was not listed as an essential support. As is noted below with regard to Section T.2 of the Settlement Agreement, Individual #185 was exhibiting problematic behavior, including aggression towards staff and peers, and it did not appear that the community provider had involved a psychologist or behavior analyst to assist in addressing the concerns. ▪ Similar to Individual #185, Individual #27's CLDP provided extremely weak requirements related to work/employment. As a result, he was provided inadequate supports in the community. At the time of the Monitoring Team's review, Individual #27 was attending the same day habilitation program as Individual #185. He indicated that he was "bored." Again, although the provider agency was actively working towards identifying better alternatives, it was unclear why the team did not require that these supports be available at the time of Individual #27's transition. According to the narrative in Individual #27's CLDP: "[Individual #27] is currently working with the off campus lawn crew. He is doing very well with completing his tasks and with his attendance. [Individual #27] would like to work at Wal-Mart on a full time basis. Discussion held at CLDP included informing provider agency to look into possibly contracting with the CCSSLC to allow [Individual #27] to continue his job with off campus janitorial work." Although it is far from ideal for an individual to transition to the community, but continue to work at the Facility, the lack of supports in the community at the time of Individual #27's transition resulted in his taking a huge step backwards from paid, meaningful work, to a day habilitation program that offered some social and recreational activities, but no vocational opportunities. The outcome also was not consistent with Individual #27's stated preference to work on a full-time basis. Individual #27's CLDP did include a non-essential support for the provider to contract with CCSSLC for vocational training, but Individual #27 subsequently indicated he did not want to return to the Facility. Page 13 of Individual #27's CLDP included a lengthy non-essential support that listed a number of medical needs. However, it did not specify in measurable terms what supports were needed to address each of these needs. Specifically, no timeframes were provided or specific actions to be taken. For example, the	

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		list included monitoring of his hypertension, but did not indicate how frequently or by whom. A number of medications were listed with the notation that the community provider should "monitor" them. Again, it was not clear whether this meant monitor that the medications were being provided, monitor for side effects, and/or ensure review by a physician. The frequency of monitoring was not indicated. To assist in ensuring there are clear expectations for the community provider, each protection, support, or service should be listed separately in measurable terms. On page 14, some of his medical and dental appointments were listed in measurable terms (e.g., dates by which appointments needed to be scheduled or held), but because numerous appointments were contained within one sentence/paragraph, they were not listed as individual, measurable outcomes to be achieved for the individual. Each appointment should have been a separate requirement so that compliance with each could be determined. Although a copy of his probation requirements were included in the assessment packet, a number of requirements should have been listed in the CLDP, such as attending a high school equivalency program, and attending counseling for substance abuse. It appeared that the community provider was assisting him in completing these requirements, but they should have been identified as essential or non-essential supports in the CLDP. A non-essential support was listed as counseling, but this support was not measurable. The frequency of counseling was not listed, and the type of counseling or the goals for the counseling were not listed. It also was not clear, once counseling options were identified, that consent would be sought to share information related to Individual #27's previous counseling to assist in the transition. The CLDP indicated that Individual #27 had a license, but had a history of running stop signs and getting tickets. An in-service training session on this topic was listed as a non-essential support. It was unclear if restrictions related to driving were in place at CCSSLC, and, if so, how these were going to be transitioned to the community. The Living Options Discussion Record in Individual #27's 2/4/10 PSP identified a number of supports his team determined to be necessary for a safe transition. Based on review of the CLDP, not all of these supports were addressed, nor was there justification for not addressing them. For example: o His PSP stated: "[Individual #27's] previous group home placement resulted in him running away from the home and becoming involved	

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		with drugs." Other than providing 24-hour awake staff, no specific supports were included in the CLDP to attempt to prevent this from recurring. o It also stated: "[Individual #27] also would require nutritional services to help maintain an appropriate diet that addresses his high blood pressure needs." No mention was made specifically of nutritional supports in the CLDP. There were references to the community provider monitoring his diet, but not to professional nutritional services. o Regular nursing services were listed in the PSP as an ongoing needs. Although the PSP did not define the level of nursing support, or the role of nursing, there was no reference to nursing supports in the CLDP. ▪ The narrative section of Individual #66's CLDP provided a list of supports her team had identified during her 3/3/10 PSP meeting as necessary for her to transition. However, not all of these were incorporated into her CLDP, dated 9/21/10. For example: o The narrative stated that "she would need assistance medically to monitor her diabetes, staff who are knowledgeable and trained in the area of diabetes and assisting her with taking her med[ication]s and administering her insulin injections." A number of her medical supports were clearly defined in measurable terms. For example, the CLDP included non-essential supports for community provider staff to monitor her diabetes, and complete finger sticks four times a day. However, there was no reference of the need for nutritional supports to be provided, or for staff to be competent with regard to the many aspects of supporting an individual with diabetes. o One of the barriers the team identified was that Individual #66 "needs to be active and involved. When she is not active she sits and loses interest in caring for herself. She will not bathe, exercise or care for her diabetes. [Individual #66] is 187 [pounds] overweight and needs to be active for her health." No requirements regarding activity were included in the CLDP. Eating at McDonald's was included as a social activity, as well as shopping and buying tobacco products. None of these included exercise. Expectations for her day program activity were not defined, but were merely listed as day habilitation and a referral to DARS. Individual #66's CLDP included a requirement that the community provider implement her BSP. However, as noted for other individuals, Individual #66's CLDP did not include requirements that the community provider make available a psychologist or behavior analyst to regularly review the BSP, train staff,	

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		conduct assessments, and, as necessary, make changes to the BSP. Likewise, although the CLDP included a requirement that community staff be trained on the PSP, presumably including the BSP, no requirements were listed with regard to who would be trained, what level of mastery community provider staff needed to demonstrate, or where and how the training would be provided (e.g., community provider staff shadowing CCSSLC staff, classroom training, etc.). Based on interview with Facility staff, since her original transition, Individual #66 had moved from one residential site to another supported by the same community provider, due to the first home's inability to provide her with the necessary structure, resulting in regular calls to the police to address behavioral issues. Although it is positive that another option was available for this individual, the need for such structure and the availability of behavioral supports should have been defined clearly in her CLDP. This would have assisted in ensuring that her transition was smooth, and that she was provided with the supports she required for success in her new setting. ▪ Individual #344's CLDP did not address what appeared to be a number of relevant recommendations from the 45-day assessments that were completed. The following provides a few examples: o Her Habilitation Therapies discharge summary included the following recommendation: "Continue Physical/Nutritional Management Plan (PNMP) for safe dining. This plan is monitored at least annually by OT/PT for appropriateness. Report discrepancies or changes in functioning to Therapy for review." Although her CLDP identified, as an essential support, that CCSSLC staff would complete in-service training with provider staff on the PNMP, and as a non-essential support that she required a pureed diet with regular fluids and no cheese puffs, no requirements were included regarding the need for annual review by and OT/PT on the appropriateness of the plan and/or the availability of an OT/PT to provide consultation as necessary. o Her psychological assessment included a number of important recommendations that were not addressed in the CLDP without justification for not including them. For example, "Provide [Individual #344] with a full day of active treatment," "Continue vocational placement. [Individual #344] needs to be involved with work that is meaningful to her," and "continue to track data on [Individual #344's] maladaptive behavior so that the consulting psychiatrist will re-evaluate the need for Depakote, Buspar and Prozak (sic) to be prescribed psychoactive medication… The PST strongly recommends that her medication remains constant until there is an imminent need to change them. [Individual #344] has been stable in (sic) current medications and dosages."	

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		The working draft of Individual #133's CLDP was reviewed as a sample of the revised format and process. Individual #133's team had made a referral for placement on 9/22/10. The CLDP documented the deliberations of the team on this date, as well as the decisions that had been made with regard to community providers to which visits would be made to assist in the selection process regarding appropriate home and day/vocational sites. Although the team had documented a number of discussions regarding Individual #133's preferences, as well as needs for protections, supports, and services, the essential and non-essential support section of the CLDP had not yet been drafted. Beginning at the time of the referral, the team should begin drafting this section of the plan, and should continue to add to it throughout the process. As was noted above, the CLDP should be a document that assists the individual and his/her team in making decisions about whether or not specific providers are able to address the individual's preferences, as well as their needs for protections, supports, and services. Populating this section of the plan as early in the planning process as possible would provide a tool for teams to use as visits are conducted and deliberations occur regarding the ability of various community providers to support the individual. Individual #133 had a complicated set of needs, including the need for physical and nutritional management supports, medical and nursing supports, psychology/behavioral supports, and vocational services. Individual #133 also was able to communicate her preferences, and had made some specific requests regarding her community supports. Although much of this information was included in narrative summaries such as the Living Options Discussion Record, and PSP Addendums, it often was not stated in measurable terms. For example, the narrative suggested that she needed nursing supports, but did not identify whether this meant 24-hour nursing supports, availability on an on-call basis, or a set number of visits a week. Likewise, the level of nursing training/certification (e.g., RN or LVN) was not specified. The supports to be provided by such nursing staff were not delineated. This is a good example of the type of detail that is necessary when decisions are made regarding whether or not a provider has the resources to support an individual. At the time of the Monitoring Team's visit, Individual #133 had been refusing to adhere to a schedule for having her legs wrapped to treat severe edema. This had led to an infection, and placed her at risk for skin breakdown. The Facility's OT/PT staff were visiting her a few times a day to offer to complete the wrapping. There was concern that this level of support would not be available in the community. The psychology staff had been working with Individual #133 and the rest of the team to address these refusals. Again, the essential and non-essential section of the CLDP should be populated with measurable supports that describe the level of involvement that would be needed from various clinicians to meet Individual #133's needs. Based on these criteria, determinations would then need to be made as to whether such supports could be made available in a particular community setting. If	

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		such supports could not be provided, they would need to be identified as obstacles to transition, and, accordingly, plans developed to overcome them. With regard to Monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, the MRA's review appeared to be a general safety assessment as opposed to an individualized assessment based on the essential supports identified by the team. The only assurances that the MRA staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the essential supports were in place appeared based on a "meeting with the site administrator/manager." The form included two related questions, including: 1) "Did the site administrator/manager have a copy of the consumer's draft Community Living Discharge Plan and know the outcomes important to the consumer or legally authorized representative"; and 2) "Did the site administrator/manager verify services and supports could be provided that are necessary to assist the consumer in achieving the outcomes?" (Emphasis added.) Responses to these questions did not represent adequate proof that the essential services required by the CLDPs were in place. None of these forms, for the sample reviewed, provided any additional documentation to show that the MRA representatives had actually confirmed that the individualized essential supports were in place. However, the Facility had begun to implement the new process of having the Post Move Monitor conduct a pre-move site visit designed specifically to determine if the essential supports were in place. A review was conducted of four individual's pre-move site visit documentation, including the information for Individual #27, Individual #185, Individual #11, and Individual #344. All four (100%) appeared thorough, and included each essential support listed in the individual's CLDP. They identified the evidence that had been reviewed to determine that the essential support was in place. They also appeared to have been completed in a timely manner, generally on the date of the individual's transition. The process will become more complicated as more essential supports are appropriately identified in individuals' CLDPs. This is substantial progress, however, in meeting this requirement of the Settlement Agreement. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress was noted with regard to the pre-move confirmation of essential supports, substantial work was still needed in adequately delineating the essential and non-essential supports in individuals' CLDPs.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans	The Facility was asked to provide the audits/monitoring forms that had been completed related to Section T of the Settlement Agreement for the two-month period prior to the Monitoring Team's review. The Facility was using the review tool the Monitoring Teams developed. Nine completed tools were submitted. Four of the nine had been completed	Noncompliance

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	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.	by the QI Department, two by the Admissions Placement Coordinator, and three by the Post Move Monitor. Seven of the completed forms related to Section T.1, and the remaining two covered Section T.2. However, many of the forms, particularly the ones for Section T.1 were incomplete. Based on a review of the forms submitted, the following concerns were noted: ▪ In order to answer all of the questions on the forms, a number of activities need to be undertaken, and a number of samples selected and reviewed. For example, policy questions need to be answered by reviewing policies, and procedures. Other documentation needs to be reviewed on a Facility-wide basis, such as documentation of educational activities, the Facility's Community Placement Report, and documents related to quality assurance efforts. In addition various samples need to be selected of individuals who: 1) are presently at the Facility, to review their PSPs and the educational activities in which they have participated; 2) have had a Community Living Discharge Plan developed; 3) have left the Facility and transitioned to the community; and 4) have had alternate discharges. It did not appear that the monitoring activities had been divided in this way, but rather efforts had been made to answer as many questions as possible on the forms by reviewing one individual's record for each form completed. ▪ The Facility's POI indicated that, based on reviews completed, a determination had been made that the Facility was 30 percent in compliance with Section T of the Settlement Agreement. It was unclear how this conclusion had been reached. The sample audits completed did not result in an overall score. The monitoring tools did not appear to have been weighted, making an overall score fairly meaningless. ▪ It appeared that a QI staff member and the Post Move Monitor each had conducted a review of Individual #125. It was not clear if this was an attempt to determine inter-rater reliability. The results were somewhat different, although similar in most respects. The Post Move Monitor's review was not dated, but appeared to have been completed at a later time than the QI staff member's review. More documentation was referenced in the Post Move Monitor's report than in the QI staff member's review. ▪ From the perspective of being consistent with the Monitoring Team's findings, the sample of reviews conducted raised questions. For example, the Facility staff consistently indicated that the MRA pre-move review had adequately confirmed that essential supports were in place. As indicated above, the MRAs review was inadequate, and did not include a review of the specific essential supports that teams had identified. The forms generally indicated that either there were no obstacles to transition to the community or teams had adequately identified them and developed plans to address them. This was generally not	

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		consistent with the Monitoring Team's findings. It was not clear whether or not Facility staff were looking at the quality of the documentation or just the presence or absence of documentation. Although some progress had been made in this area, the Facility was at the beginning stages of developing and implementing quality assurance processes necessary to assess its implementation of Section T. The Facility should continue to expand its monitoring activities in this area, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate, the monitoring tools, particularly to separate out the different types of reviews to be completed using different methodologies and samples; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.	
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	In response to a document request, the Facility provided a list that identified one obstacle each for nine individuals. For four individuals, the obstacle listed did not appear to be an obstacle, because the report stated "exploring community options." Four individuals had "LAR choice" listed as the obstacle, and the remaining individual had "behavior/psychiatric" listed as the obstacle. As noted above, the obstacles that teams were identifying were not yet adequately defined. It would be more helpful if obstacles to placement were more specifically defined. The broad categories of "LAR Choice," and "Behavior/Psychiatric," for example, provided little information about what the obstacle or barrier was. In order for the State and the Facilities to adequately address barriers, they should be: 1) defined with sufficient detail to allow the State to identify and address issues related to the current community system; and 2) identify the protections, supports, and/or services that are currently lacking or not available to allow transition to the community. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, or the timeliness with which services can be accessed in the community (e.g., certain types of medical services) might be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes to the community system. Likewise, when an individual or LAR indicates that they do not want to consider	Noncompliance

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	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.	transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. The State needs to collect and analyze such information, and address such concerns to the extent possible.	
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.	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. For the time period between 1/1/10 and 12/31/10, the report listed: ▪ Current Referrals: This included individuals who had been referred by their teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Seven individuals were included on this list. ▪ Community Placements: This included individuals who had transitioned to the community, including their name, date of referral, and date on which their transition to the community occurred. This included 20 individuals. ▪ Rescinded Referrals: This list represented individuals who had been referred for community transition, but whose referral later had been retracted. It included the individuals' names, date of referral, date on which the referral was rescinded, and a brief reason for the closure of the referral. Four individuals were included on this list. The reasons for referrals being rescinded included the LAR's choice for two individuals, and for the remaining two individuals an Interdisciplinary Team (IDT) decision, one due to behavior/psychiatric reasons, and the other due to medical reasons. During December 2010, the Monitoring Panel requested some additional information regarding transition in order to capture categories of individuals who have either requested community transition, or whose teams have determined they can be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template used by each of the Facilities. For meetings occurring between 9/1/10 and 12/31/10, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the names of two individuals with the date of the meeting at which the decision not to refer was made. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included five individuals, including the date of the meeting and a brief description of the reason for the referral not being made. For two of the individuals, the MRA was not present, which is a requirement for a referral being made. In these cases, the teams reportedly were required to reconvene a meeting at which the MRA could be present. As noted above, this had not been done timely for either	Substantial Compliance

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		individual. For the other three individuals, the reason was noted as "exploring community options." ▪ LAR Prefers Community, Not Referred: No individuals were listed in this category. The Monitoring Panel asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State has indicated that at this time, its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested. The Monitoring Team looks forward to reviewing this information in the future.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support	Timeliness of the Checklists Post-move monitoring documentation was reviewed for eight individuals (Individual #108, Individual #66, Individual #27, Individual #185, Individual #11, Individual #344, Individual #258, and Individual #84). This sample represented all (100%) of the individuals who had transitioned from CCSSLC to the community since the last review, and one individual who had transitioned from another SSLC, but was living in the CCSSLC area. For the eight individuals, 20 reviews should have been completed. Of the 20 required visits, 19 (95%) had been documented as having been completed on time. The 45-day review for Individual #258 had been completed 12 days late. Documentation did not consistently show that visits had been made to both the residential and day sites of the individuals. Although individuals' CLDPs generally included extremely weak requirements regarding day/vocational supports, seven out of the eight reviewed included some basic requirement that the individual be involved in day/work activities. For these individuals, 17 reviews should have been conducted. Documentation was present to show that in four out of the 17 (24%), the post move monitoring visits had occurred at both the residential and day/vocational sites. It should be noted that the revised post-move monitoring format provides clearer documentation of the sites at which the individual was observed. It also would be helpful to clearly delineate if reviews were conducted at a site (e.g., record review, etc.), but the individual	Noncompliance

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	is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	was not present. In order to adequately ensure that all essential and non-essential supports are in place, each of the seven, 45, and 90-day visits should be conducted in each of the settings where protections, supports, and services are being provided. <u>Content of Checklists</u>: With regard to the content of the checklists, a number of the checklists reviewed utilized the revised format, which generally was consistent with the format attached to the SA as Appendix C. A significant improvement was that the methodology being used to confirm the existence of necessary protections, supports, and services was generally stated. This was facilitated by the addition of an "evidence" column, which identified the evidence that the Post Move Monitor was expected to review during the monitoring process. A "comments" column also facilitated provision of an explanation of what was done to confirm compliance, as well as narratives describing both positive and negative findings. An overall concern was that there was no longer a "Yes/No/N/A" column on the checklist, and it was only by reading the narrative in the comments section that a determination could be made with regard to whether or not the essential and non-essential supports were in place. The checklists reviewed generally were completed thoroughly. However, some concerns were noted with regard to ensuring and/or documenting that each essential and non-essential support was in place in a timely manner. At times, requirements in the CLDPs included multiple requirements, and the monitoring completed did not address each of the separate requirements. Some examples of the concerns noted included: ▪ The following concerns were noted with regard to the post-move monitoring conducted for Individual #185: o One of the essential supports listed was that Individual #185 be provided 24-hour awake staff. In the comments section, this requirement was repeated, but it was unclear if monitoring had occurred to ensure it was in place. o One of the non-essential supports was that the community provider would "provide [Individual #185] with a Dietician – annually, monthly weight checks, three whole peanut butter and jelly sandwiches a day to maintain weight and diet soda (caffeine free) as per CCSSLC evaluation." The notes indicated that the sandwiches were being provided. However, there was no reference to whether or not the provider had identified a dietician, or if monthly weight checks were being completed. o Another non-essential support was that the provider would "provide [Individual #185] with medical care as needed to ensure his good health to include monitoring of his active medical diagnosis of constipation." The notes indicated that his primary care physician had seen him. There was no indication, though, if the Post Move Monitor had	

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		confirmed that the provider was monitoring him regarding his constipation diagnosis (e.g., a bowel movement chart). o An example of multiple requirements being included in one box on the post-move monitoring checklist was #2.H, which required monitoring of Individual #185's medication, establishing a relationship with the primary care physician within 30 days, establishing psychiatric services for medication review, and completion of an electrocardiogram (EKG). To facilitate monitoring, it would have been helpful to separate each of these requirements. In the 90-day review (similar to the seven and 45-day reviews), the Post Move Monitor commented on the fact that there had been no medication changes, but did not appear to have reviewed the Medication Administration Record to ensure the provider was adequately monitoring his medications to ensure he received them, to note side effects, etc. The Post Move Monitor noted that Individual #185 had seen his primary care physician and had an appointment scheduled with a psychiatrist. In the written report, there was no mention of whether an appointment had been scheduled for an EKG, which was due the following month. During the onsite review, the Post Move Monitor had asked about the EKG, and indicated she would call the provider to find out if it was scheduled. This was not documented in the report. o A non-essential support was for Individual #185's BSP to be continued. The Post Move Monitor's comments for the 90-day review indicated that review of the record indicated that he had had several behaviors requiring redirections, and had bitten day habilitation staff. There was no indication if staff had been following the BSP. During the visit, which a member of the Monitoring Team attended, Individual #185 exhibited behaviors and staff were interviewed with regard to how they handled his behaviors. The Post Move Monitor did not comment in her report on whether the strategies being used were consistent with the BSP. ▪ Individual #258 had her seven, 45, and 90-day reviews completed. The first two appeared to have been completed by an Admissions Placement Coordinator from another Facility. For these reviews, many indicators had not been addressed at all, including a number of important health-related requirements. The CCSSLC Post Move Monitor completed the 90-day review. It utilized the old format, so limited information was provided. However, it appeared that all of the indicators had been reviewed. ▪ It should be noted that although Individual #11 was a resident of CCSSLC, a Post Move Monitor at another Facility was conducting his reviews, because he had moved out of the area. Individual #11's CLDP required that beginning on the date of his transition and on an ongoing basis, he would have pictures consistent	

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		with the CCSSLC speech recommendations to help him express himself, and the community provider would use reinforcers to assist him in maintaining his daily schedule. This was to be evaluated by reviewing his picture book, and the daily progress notes at his day habilitation program and home. The seven-day review was the only one that had been completed at the time of the Monitoring Team's review. For this indicator, it noted: "No paperwork provided. Caseworker noted that they usually wait two weeks before starting progress notes." The provider's practice was inconsistent with what was required by the CLDP. However, this was not addressed in the action plan/follow-up section of the report. Community providers need to be held to the standards/requirements included in the CLDP. It also should be noted that a number of requirements could not be evaluated, because the individual and some of his paperwork were not at the program. Individual #11 had gone to an appointment about which the Post Move Monitor had not been aware. This resulted in incomplete monitoring. It was unclear why another visit was not made. ▪ It should be noted that a PMM from another SSLC completed the 90-day review for Individual #66. Individual #66 originally had moved to a group home near CCSSLC, but subsequently moved to a group home with the same provider outside of the area covered by CCSSLC, because it was a better environment for her. The Post Move Monitor from CCSSLC had conducted the seven-day and 45-day reviews. These were thorough, and particularly the 45-day review, contained significant narrative information describing the methodologies used to confirm the existence of essential and non-essential supports, as well as information related to Individual #66's adjustment to her new home. Unfortunately, the 90-day review, which another Post Move Monitor conducted, appeared to be largely a copy of the 45-day review with little new information added. Because most sections were a verbatim copy of the previous review, it was difficult to tell if this Post Move Monitor had actually completed the review using the same methodology as the CCSSLC Post Move Monitor and was making the same findings, or if the language just had not been deleted or modified. The primary reasons for conducting post-move monitoring are to identify if all protections, supports, or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. Generally, it appeared the issues that were being identified were followed through to conclusion. Notes identifying actions taken were documented on the forms. An important addition to this process was the expectation that teams would meet after each post-move monitoring visit was completed to review the report, and determine if additional action needed to be taken. Although at the time of the review, this expectation was fairly new, its implementation was beginning to be seen at CCSSLC. For example: ▪ During the review for Individual #185 completed the week of the Monitoring	

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		Team's onsite review, issues related to his behavior were noted. These behaviors were not target behaviors on his current BSP, but it was unclear if they had been issues in the past. The Post Move Monitor told the community provider and documented in her report that she would bring the issue back to his CCSSLC team to review and potentially offer assistance. As noted below, though, it was unclear if the community provider had adequate behavioral supports and/or resources in place or available. There were some issues identified for which it was not clear that adequate corrective actions had been identified and addressed. For example: ▪ An essential support for Individual #185 included obtaining a number of documents to allow enrollment with DARS. This was the responsibility of CCSSLC. Based on the documentation, it appeared that CCSSLC assisted Individual #185 to obtain his birth certificate and Social Security Card, but not his Texas Identification Card. On the day of his transition to the community, it was noted that the community provider would assist with this task. The seven, 45, and 90-day post-move monitoring reports continued to note that the provider would assist, but no updates were provided, and this was not included as an action step with any description of activities underway to obtain the card, which was listed as an essential support. ▪ As noted above, at the 90-day review for Individual #185, for which a member of the Monitoring Team was present, he exhibited a number of behavioral issues, and it was reported that he had engaged in behavior in which he had injured staff and threatened the safety of other individuals at the day program. The community provider's response was that he had an appointment scheduled with the psychiatrist. The Post Move Monitor indicated to the provider and wrote in the narrative section of the monitoring report in the non-essential support section that she would consult the CCSSLC team. Although this was a positive step, there was no action step in the follow-up section of the report indicating that the CCSSLC team would provide any necessary input. More importantly, though, there was no requirement for the provider agency to address Individual #185's increasing behaviors by, for example, consulting a psychologist or behavior analyst to review and revise, as necessary, his BSP. It should be noted that given this individual's history, his CLDP should have included a requirement that the provider have a psychologist and/or behavior analyst involved as a member of his team from the time of his discharge. However, even absent this component of the CLDP, a reasonable expectation to address the concerns noted would be for the provider to be asked to identify and provide such supports as soon as possible to address Individual #185's escalating behavior. ▪ Similarly, Individual #344's seven-day review was completed with a member of the Monitoring Team present. Toward the end of the review, a direct support	

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		professional indicated that Individual #344 had been scratching, screaming, and hitting staff. As the Post Move Monitor documented in the report, these incidents had not been documented. CCSSLC staff reminded the community provider staff that they had been trained, and pointed out the sign-off sheet that staff had signed. Other than encouraging the direct support professional to read the BSP, no further action steps/follow-up was noted with regard to this finding. It was concerning that staff were not familiar with the BSP. It would have been reasonable to ask the community provider to retrain staff, and/or have their psychologist/behavior analyst become involved in addressing concerns raised by staff. This was another example of the CLDP providing little structure with regard to behavior supports. Other than CCSSLC staff training provider staff on the BSP, no other requirements were included, such as requiring implementation of the plan, review by a psychologist/behavior analyst on a regular basis, review of data, modifications to the plan as necessary, etc. Overall, progress was being made with regard to this provision. The Facility had begun to use the new post-move monitoring process, which included a number of important improvements. Monitoring visits were generally being completed timely. Areas needing continued improvement to reach compliance included ensuring that monitoring visits include all of the sites at which essential and non-essential supports are provided, all essential and non-essential supports are reviewed and a rating is provided (i.e., Yes, No, N/A), and adequate follow-up is taken and documented.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the on-site review, a member of the Monitoring Team accompanied the Post-Move Monitor on three post-move monitoring visits for Individual #344, Individual #185, and Individual #27. The Placement Coordinator also attended two of these visits. The Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. The Post Move Monitor also offered suggestions to providers to address outstanding issues, and, on at least one occasion, indicated she would consult with the individual's team at CCSSLC to obtain additional information that might be helpful to the community provider and the individual. In reviewing and comparing the monitoring reports with observations made on site, the following concerns were noted: ▪ As noted above with regard to Section T.2.a of the Settlement Agreement, for Individual #185, concerns were noted with regard to each requirement of the CLDP not being reviewed and findings made. In addition, adequate follow-up action was not identified to address Individual #185's escalating behaviors. ▪ As also noted above, there was a discrepancy between Individual #344's	Noncompliance

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		documented behavioral incidents and reports from staff regarding her behavior. Although this was discussed in the report, the monitoring report did not document a problem with regard to staff being adequately trained on the BSP, with a corresponding action plan. It should be noted that the concerns identified above with regard to the continuing need for improvement in the depth and quality of CLDPs will affect the level of monitoring that will be required. As CLDPs are improved, and additional measurable services, supports, and protections are included in the plans, the expectations for the Post Move Monitor will increase. As is noted above, it is essential that modifications be made to the CLDPs to ensure they include comprehensive and measurable definitions of the protections, services, and supports provided. This will require the Post Move Monitor to conduct many more observations of, for example, meal times, staff interactions with individuals, and/or the environment, and will require much more extensive review of data, such as behavioral data, data related to PNMPs, and interviews with direct support professionals to ensure their understanding of such supports, etc. Post-move monitoring activities will need to keep pace with the evolution of the community living discharge planning process. As noted above, generally, the post move monitoring processes were improving. However, due to the concerns noted with regard to the monitoring the Monitoring Team observed, a finding of noncompliance has been made.	
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 -**		

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	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	Since the last review in July 2010, CCSSLC had not had any alternate discharges. As a result of no alternate discharges having occurred, this component of the SA was not rated.	Not Rated

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State should provide the Facility with guidance regarding the process to be used for assessing individuals for placement/transition to the most integrated setting appropriate to meet the individuals' needs.
2. The professional teams supporting individuals at CCSSLC should independently make recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.
3. When the reason for a referral not being made is due to the lack of an MRA representative's presence at a meeting, all efforts should be made to

schedule a meeting as soon as possible at which all necessary participants are present.

4. With regard to policy:
   a. State policy, as well as Facility policy, should be modified to reflect the changes that have occurred regarding transition procedures so that expectations regarding practice are clearly delineated.
   b. In addition, as appropriate, the Facility should include in its local policies any Facility-specific details that are relevant to full implementation of the State policy.
5. The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. CCSSLC also should continue to add creative and individualized educational activities to meet the needs of various individuals and families/guardians, including action plans in individuals' PSPs designed to meet their specific needs. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
6. Teams should be provided with additional competency-based training on the identification of obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. Such obstacles should be defined in terms of protections, services, and supports that currently are lacking or not available in the community. Obstacles also should be defined with sufficient detail to allow the State to identify and address issues related to the current community system. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, the timeliness with which services can be accessed in the community (e.g., certain types of medical services) might be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes.
7. Likewise, when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the Facility and the State.
8. As teams begin to better define obstacles to movement, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility, this discussion should be memorialized in the PSP to document that individuals and their families are making informed decisions with regard to an individual's living options.
9. With regard to the revised Community Living Discharge Plan template and process:
   a. Because the CLDP is a document that would need to be updated at many stages of the process, dates should be included each time the document is revised. For example, such dates could be added to the first page, or placed in a footer.
   b. Psychiatry should be added to the list of summaries and assessments.
   c. Likewise, if the PNMT has conducted specific assessments, and/or made recommendations, these should be included.
   d. The PST can, and should, make certain action plans (e.g., training objectives and/or service objectives) essential or non-essential supports if the PST believes that implementation of any of these plans is important. DADS should remove the statement on page 12 related to the team only being able to recommend the implementation of action plans, because it appears to be at odds with the State's desire for transition to grow out of the PSP process.
   e. The pre-move site review also should include the list of standard items on page six (e.g., provision of 30-day supply of medication, current physician orders, etc.). This could be added to the list on page 23.
   f. The pre-move and post-move monitoring forms should be revised to clearly indicate the presence of absence of an essential or non-essential protection, support, or service (i.e., Yes, No, N/A).
10. Essential and non-essential supports should be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process should be better defined.
11. Beginning at the time of the referral, the team should begin drafting essential and non-essential sections of the plan, and should continue to add to them throughout the process. The CLDP should be a document that assists the individual and his/her team in making decisions about

whether or not specific providers are able to address the individual's preferences, as well as their needs for protections, supports, and services. Populating this section of the plan as early in the planning process as possible would provide a tool for teams to use as visits are conducted and deliberations occur regarding the ability of various community providers to support the individual.

12. Particularly with regard to the transition of medical and other clinical information, a summary should be developed, including but not limited to, the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.) to facilitate the transition of this information to community medical care providers. One addition that should be made to the nursing discharge form is Axis I, II, and III diagnoses. In addition, similar summaries should be developed and implemented by medical and psychiatry staff.
13. As requested by the Monitoring Panel, a final category should be added to the Community Placement report that includes a list of names of individuals who would be referred for community transition by the team except for the objection of the LAR.
14. Clear expectations should be established with regard to the frequency and types of monitoring visits that need to be completed, the process that needs to be used for monitoring, and the documentation that needs to be maintained.
15. In order to adequately ensure that all essential and non-essential supports are in place, monitoring visits should be conducted in all settings to review protections, supports, and services are being provided.
16. With regard to the revised post move monitoring checklist format:
    a. In addition to indicating where the individual was observed, Post Move Monitors should document consistently the sites visited (e.g., home, day/vocational, provider office, etc.).
    b. A column should be added to provide a clear rating of whether or not an item/activity was present or had been completed (i.e., Yes, No, N/A).
    c. As the format is populated for each individual, the information in the CLDP should be broken down into indicators that measure one outcome. This would assist in ensuring that when a rating is provided, it is clear what is present, and what remains as an outstanding issue.
17. The action plans that are part of post-move monitoring checklists should be more focused on resolving the issues identified.
18. Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.
19. With regard to monitoring activities related to the Facility's performance with this section of the SA, the Facility should:
    a. Continue to expand its monitoring activities in this area, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, and samples to be selected);
    b. Modifying, as appropriate, the monitoring tools, particularly to separate out the different types of reviews to be completed using different methodologies and samples;
    c. Providing specific, written instructions on the implementation of the tools;
    d. Training staff who will conduct the monitoring on the review tools and their implementation;
    e. Ensuring the reviews evaluate quality as well as the presence or absence of items;
    f. Establishing inter-rater reliability; and
    g. Analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Policy on Consents – Section U, including the following related procedures: ▪ U.1: Identifying Needs and Requesting Personal Advocates, revised 12/8/10; ▪ U.2: Obtaining Guardian Consent prior to Non Routine Medical Appointments, revised 12/8/10; ▪ U.3: Completing Guardian Document Check Verification form, revised 12/8/10; ▪ U.4: Obtaining Consents for Medication for Behavior Management, revised 12/8/10; and ▪ U.5: Maintaining Current Guardianship Papers on File; o CCSSLC Draft Policy: Rights and Protection – Section UU, undated, including the following related procedures: ▪ UU.1: Training Staff on Rights, revised 12/8/10; ▪ UU.2: Assigning Level of Supervision, revised 9/18/10; ▪ UU.3: Ensuring Individual Rights, revised 12/8/10; ▪ UU.4: Exercising Right to Vote, revised 12/8/10; ▪ UU.5: Human Rights Committee (HRC) Member Recruitment Plan, revised 12/8/10; ▪ UU.6: Review of Rights Restrictions by HRC, revised 12/8/10; ▪ UU.7: Searching Individual Served for Contraband or Prohibited Items, revised 12/8/10; ▪ UU.11: Participating in and Documenting Level of Supervision Oversight Committee (LOSOC) Team Minutes, revised 9/18/10, and; ▪ UU.11.1: LOSOC Meeting Minutes; o Individuals Identified Without a LAR [Legally Authorized Representative] Prioritized by Family/Contact Visitation Frequency; o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care; and o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 592. Rights of Persons with Mental Retardation, Subchapter A. General Provisions, Section 592.054. Duties of Superintendent or Director ▪ **Interviews with**: o Daniel Dickson, Quality Enhancement Director; and

	○ Karen Forrester, Human Rights Officer
	Facility Self-Assessment: In its POI, the Facility recognized that it was not in compliance with the requirements of Section U of the Settlement Agreement. This was also reflective of interviews with staff, and was consistent with the Monitoring Team's findings. Although compliance had not been achieved, the POI indicated that staff had taken steps to attempt to develop a prioritized list of individuals requiring guardianship, and was awaiting final State policy on the subject.
	Summary of Monitor's Assessment: DADS Central Office was still in the process of finalizing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of this SA requirement. On January 28 and 29, 2011, meetings were scheduled with the State Office and the Human Rights Officers from the SSLCs to review the draft policy and discuss additional changes, as well as implementation. At the time of the review, the process for assessing individuals' "functional capacity to render a decision" and provide informed consent was still not being completed using a standardized tool. It was anticipated though that the State Office policy would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area. Since the last review, the Facility had reviewed the list of individuals who did not have guardians. The Human Rights Officer had developed a prioritized list based on a number of factors, including the level, if any, of family or correspondent involvement in the individual's life, his/her ability to communicate preferences, the health needs of the individual, and whether or not the individual had rights restrictions in place. Although this appeared to be a thoughtful process, it will be important, once the State Office policy is finalized, for individuals' teams and the Guardianship Committee to be involved in the prioritization process using similar objective criteria. The prioritized list provided to the Monitoring Team included 208 individuals. Based on the current census of 283 individuals at the time of the review, this resulted in an estimated 73% of the individuals at CCSSLC being in need of guardians. Since the last review, no guardians had been identified for individuals who needed them. It will be essential that adequate resources to address this need be identified.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional	As reported in the Monitoring Team's previous reports, although CCSSLC had some of the preliminary processes in place to identify the need for individuals to pursue the guardianship process, the Facility had not met the requirements of this provision of the Settlement Agreement. Facility staff continued to recognize this as an area in which they needed to make additional efforts.	Noncompliance

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	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.	Staff indicated that DADS Central Office was still in the process of finalizing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of this SA requirement. The State Office had provided CCSSLC with a copy of the draft policy from which a draft Facility policy and some related procedures had been developed. On January 28 and 29, 2011, meetings were scheduled with the State Office and the Human Rights Officers from the SSLLCs to review the draft policy and discuss additional changes, as well as implementation. Once the State Office policy is finalized, CCSSLC should review and revise, as necessary, its policies. For example, some of the concerns noted with regard to the CCSSLC policies included: ▪ Although there were various policies/procedures that addressed informed consent, the policy/procedure entitled Obtaining Consent for Medication for Behavior, #U.4, did not include ensuring that the consent obtained was informed consent. For example, the policy/procedure referenced that the author of the consent form would "print and include the appropriate Patient Education Monograph(s) and affix to the consent form that identifies the corresponding medication, in addition to other restrictive practices for behavior management along with an outline of the BSP." This form was then to be sent to the guardian and/or Facility Director for review and signature. As is discussed with regard to Section J of the Settlement Agreement, it is essential that adequate information, including as necessary and appropriate verbal explanation, be provided regarding medications or other restrictive procedures to ensure that the consent is informed consent. ▪ The Rights and Protection section of the policies included references to the Human Rights Committee as a mechanism for reviewing, for example, restrictive procedures including the use of psychotropic medications. The policy entitled HRC Member Recruitment Plan, #UU.5, did not address recruitment of HRC members, but discussed the process for sending information to the HRC for review. It was almost identical to the procedure entitled Review of Rights Restriction by HRC, #UU.6. In addition, as noted by Facility staff during the on-site review, implementation of the policy the State Office was developing will require significant effort and changes to a number of practices at the Facility, including more intense involvement of individuals' PSTs in assessing individuals' "functional capacity to render a decision" and provide informed consent. At the time of the review of CCSSLC, this process was still not being completed using a standardized process, but it was anticipated that the State Office policy would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area. This might require CCSSLC to modify further	

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		its policies and procedures to ensure the State policy is implemented thoroughly and with integrity. At the time of the review, as part of the annual individualized planning process, individual teams at CCSSLC continued to identify whether an individual had a Legally Authorized Representative or not. It appeared that individual teams reviewed the Rights Assessment, that was completed prior to each individual's annual Personal Support Plan meeting, and made some basic determinations regarding whether an individual was able to make informed decisions, and/or if supports were necessary to ensure that the individual's rights were maintained with respect to decision-making. As noted in the Monitoring Team's previous reports, some of the concerns related to the current process included the following: 1) the process that teams were using to determine an individual's ability to provide informed consent was vague and did not appear to be based on specific assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship. As noted in previous reports, Facility staff interviewed recognized guardianship as a restrictive procedure that, at times, is necessary to protect an individual who has limited ability to make informed decisions. Likewise, the Texas Guardianship Statute recognized guardianship as a restrictive procedure that required due process. The statute also offered limited guardianship as a less restrictive option to full guardianship. Therefore, it is important that assessments of an individual's capacity to provide informed consent detail the areas in which they are able to make informed decisions as well as those areas in which they cannot make such decisions. Further, it is important for such assessments to identify if there are supports or resources that could enable an individual to make informed decisions, or increase their capacity to make such decisions. Since the last review, the Facility had reviewed the list of individuals who did not have guardians. A prioritized list had been developed based on a number of factors, including the level, if any, of family or correspondent involvement in the individual's life, his/her ability to communicate preferences, the health needs of the individual, and the whether or not the individual had rights restrictions in place. The Human Rights Officer mainly had completed this review and prioritization process. Based on staff interview, the next step in the process was for individuals' teams to be asked to review the priority list, and provide input. The prioritized list provided to the Monitoring Team included 208 individuals. Based on	

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		the current census of 283 individuals at the time of the review, this resulted in an estimated 73% of the individuals at CCSSLC being in need of guardians. The list was arranged according to the level of family or correspondent involvement ranging from: 1) no involvement; 2) family contact less than yearly; 3) contact from one to four times yearly; and 4) contact five or more times yearly. Based on interview with the Human Rights Officer, individuals' PSPs and related assessments were reviewed and staff were consulted to further prioritize the list related to the other factors listed above. As an example, the individual currently at the top of the list, Individual #255, was described as having no family or correspondent involvement. Although he was able to communicate his preferences, he exhibited challenging behaviors, some of which had the potential to impact negatively his health status. He had medical diagnoses that placed him at risk, including diabetes, for which health care decision-making was frequent. The compilation of this list clearly had been a time-consuming and thoughtful process. However, it was largely based on the judgment of the Human Rights Officer who had used some objective criteria. A more formalized process is needed, such as that described in the draft State Office policy. The draft policy contemplated the use of a Guardianship Committee to assist in the prioritization process. Progress was being made, but the Facility remained out of compliance with this component of the Settlement Agreement. Although the Facility had a prioritized list, a standardized process for determining individuals' functional capacity to render informed decisions still was not being used. Although the process described for prioritizing the list generally sounded as if it had been a thoughtful one, it also had not been completed using clearly objective criteria or process. Once the State Office policy is finalized, the Facility is encouraged to implement it expeditiously.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for	Based on interviews with Facility staff and review of documentation, since the last review, no guardians had been identified for individuals who needed them. The Human Rights Officer position had been filled, which should assist in this process. As noted above, the CCSSLC Human Rights Officer was scheduled to attend a meeting of all of the SSLC Human Rights Officers and State Office Staff at the end of January 2011. This collaboration should assist in the Facilities sharing ideas and resources for identifying potential guardians. However, according to CCSSLC staff, there were no known guardianship resources available in the area. For example, Facility staff did not know of any nonprofit guardianship entities to which referrals could be made. As noted above, the list of individuals requiring guardians included 208 names. Although, as also discussed above, complete assessments had not been done to identify individuals who might be able to make decisions with supports other than full guardianship, substantial	Noncompliance

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	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.	guardianship resources will be needed to address these individuals' needs for guardians. It will be essential that adequate resources to address this need be identified. In an effort to maintain current guardianships, the Facility was tracking guardianship annual renewal dates. Each year, the current guardian was required to submit an annual report to the Court. By tracking these dates, the Facility was able to send reminders and offer assistance to guardians, as needed, to complete the annual report, thereby ensuring that the guardianship did not lapse. The Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators may be appointed to assist the court in evaluating the need for guardianship, as well as to determine the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings included family members, as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs, and preferences, teams could potentially provide valuable information, both in terms of written reports, as well as verbal information, regarding individuals who become the subject of guardianship proceedings. As the State finalizes its policy on consent and guardianship, it should define the potential roles of SSLC staff in the process.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State should finalize the State Office policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding, in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either, allow an individual to make informed decisions, or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);
    c. A standard tool/process for identifying priority with regard to the need for guardianship; and
    d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court.

2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
3. Once the State policy is finalized, CCSSLC should develop and/or revise its policies related to guardianship and informed consent to reflect the State policy.
4. Based on any additional information provided in State policy regarding prioritization for guardianship, CCSSLC should review the list that identifies individuals who need the support of a guardian, and re-prioritize the list, as appropriate.
5. CCSSLC staff should collaborate with staff from other SSLCs to identify and implement potential initiatives and resources for identifying guardians (e.g., Lubbock SSLC's initiative to collaborate with local Mental Retardation Authorities and community agencies in an attempt to identify guardians for individuals they support).
6. The State should consider seeking or providing funding for a guardianship program in the Corpus Christi area that would be responsible for the identification, training, and oversight of guardians, such as those programs that are available in other parts of the state.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Policy: Recordkeeping and Plan Implementation (State Office Policy #020.1) – Section V, dated 3/5/10, including the following related procedures: ▪ V.1: General Information, revised 12/5/10; ▪ V.2: Filing, revised 12/5/10; ▪ V.3: Security of Records and Using a Special Binder in Each Active Record Area, revised 12/5/10; ▪ V.3.1: Active Record Check Out Sheet, revised 12/5/10; ▪ V.4: Unified Record, revised 12/5/10; ▪ V.5: Falsification of Records, revised 12/5/10; ▪ V.6: Quality Enhancement Audit Procedure, revised 12/1/10; and ▪ V.7: Active Record Check-Out Binder, revised 12/5/10; o CCSSLC Policy A.1: Policy and Procedure Guidelines, revised 9/1/10; o Policy Review Committee Meeting Minutes Template, dated 7/1/10; o CCSSLC Policy M.26: Respiratory Therapy – Nebulizer, revised 11/15/10; o CCSSLC Policy M.9: Integrated Progress Note and Nursing Documentation, revised 12/8/10; o Policy and Procedure Tracking, dated 12/29/10; o CCSSLC Draft Filing and Retention Schedule, revised 11/19/10; o List of Persons Responsible for Management of Records; o List of Persons Responsible for Auditing Records; o Master Record Order and Guidelines: Historical Records, revised 11/19/10; o Master Record Order and Guidelines: Active Record Purged from Units, dated 11/19/10; o Master Record Order and Guidelines: Inactive Records, dated 11/19/10; o Quality Assurance Checklists completed for last 10 records reviewed by Facility staff; and o Presentation Book for Section V. ▪ **Interviews with**: o Elena Menchaca, Unified Records Coordinator; o Lily Rodriguez, Unified Records Coordinator; and o Daniel Dickson, Director for Quality Enhancement
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section V of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. However, it was not clear that the conclusions drawn were based on objective data. Based on interviews with staff and review of documents, CCSSLC had begun to conduct regular reviews of individuals' records. As is described in further detail below with regard to Section V.3 of the SA, the Unified Records Coordinators and the QE Department had begun to conduct regular record reviews. The Facility

	recognized that in addition to reviews of the presence of items in records, it also needed to assess quality of items. Information gathered from these self-assessment processes should be utilized in future POIs to substantiate findings of compliance for Sections V.1, V.3, and V.4 of the Settlement Agreement. With regard to the development of policies and procedures, the Facility's implementation of a revised policy that established a Policy and Procedure Committee should assist the Facility in assessing its status with regard to the policies required by the SA, and for ensuring the quality of those policies.
	Summary of Monitor's Assessment: Since the State issued the new Table of Contents (TOC) for the active records, CCSSLC staff developed an action plan to address the conversion of the records from the old to the new TOC. The implementation process began in late March 2010, and was completed on 9/1/10. This was a substantial accomplishment in a short time. CCSSLC had Individual Notebooks for individuals prior to the conversion process, and reportedly, all Individual Notebooks were in place. The final phase of the process involved the conversion of individuals' historical files to the Master Record format State Office issued, which the Facility anticipated completing by March 2011. As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development. The Director for Quality Enhancement had developed a tracking system to assist in ensuring that Facility policies were consistent with State Office policies. CCSSLC was conducting reviews of at least five records each month. The system for doing this continued to need to be refined to ensure compliance with Appendix D of the Settlement Agreement. The processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends were in the beginning stages of development. There continued to be issues related to missing documents, and/or the quality of information included in individuals' records. These will need to be corrected in order to ensure that records can be adequately used for making treatment decisions.

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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.	As discussed in the last monitoring report, since the State issued the new Table of Contents (TOC) for the active records, CCSSLC staff developed an action plan to address the conversion of the records from the old to the new TOC. This process began in late March 2010. Based on documentation provided, in August 2010, four additional file clerks were hired, who reported to the Medical Department, increasing the number of file clerks to eight. At the time of the Monitoring Team's review seven of the eight positions were filled. The file clerks assisted with the conversion of the records. According to staff, as of 9/1/10, all individuals' Active Records had been converted to the new Table of Contents. File Clerks were responsible for maintaining the Active Records for the most part. One exception was the newly revised Observation Notes that direct support	Noncompliance

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		professionals completed daily. Staff on the 10 p.m. to 6 a.m. shift were responsible for transferring these from the Individual Notebooks to the Active Records on a daily basis. CCSSLC had Individual Notebooks for individuals prior to the conversion process, and reportedly, all Individual Notebooks were in place. Residential Coordinators were responsible for maintaining the notebooks. The final phase of the process involved the conversion of individuals' historical files to the Master Record format State Office issued. Issues were identified in the previous report with regard to filing notes of Registered Dieticians and inclusion of Respiratory Therapists notes in integrated progress notes. The Facility developed an action plan to address these deficiencies, and included it in its POI. According to the POI, the Facility was revising the related policies to require both of these disciplines to document their notes in the integrated progress note section of the records. The CCSSLC Respiratory Therapy – Nebulizer, revised 11/15/10, clearly set forth the expectation that Integrated Progress Notes be updated when nebulizer treatment were being administered. CCSSLC Policy M.9: Integrated Progress Note and Nursing Documentation, revised 12/8/10, had begun to be implemented. It set forth expectations for a number of specific disciplines, but also included overall requirements for integrated progress notes. In addition, a tracking system was being developed to monitor compliance with the inclusion of integrated progress notes in individuals' records. Although there had been some challenges overall with staff including documentation in the integrated progress note section, records management staff indicated that this was improving. With regard to the security of records as referenced in Appendix D of the SA, it was the expectation that records were maintained in a locked file cabinet to which staff in the homes had access. The Facility had drafted an Active Record Check out procedure. This procedure would go into effect any time an individual's active record needed to leave the unit, for example, for off campus medical appointments, or for a PSP meeting. The implementation date for this procedure was 12/5/10. Implementing such a system will assist in maintaining control over the security of the records. The Facility had made considerable progress in converting the Active Records to reflect State Office requirements. In addition to ensuring that the records are maintained properly, the completion of the Master Record conversion is necessary for compliance with this component of the Settlement Agreement.	
V2	Except as otherwise specified in this	As is discussed throughout this report, policies and procedures necessary to implement	Noncompliance

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	Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	the SA were in various stages of development. The Director for Quality Enhancement had developed a tracking system to assist in ensuring that Facility policies were consistent with State Office policies. The Facility continued to implement CCSSLC Policy #A.1 entitled Policy and Procedure Guidelines, revised 9/1/10. This policy set forth a process for the development and review of policies and procedures. It required that the Policy and Procedure Committee review all draft policies. This Committee was comprised of the Director, the Assistant Director of Programs, the Settlement Agreement Coordinator, and the Quality Enhancement Director. Based on interview with staff and review of the policy, the Committee was responsible for reviewing any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements. As appropriate, the Committee made recommendations to the policies' authors, and approval for policies was provided when all recommendations had been addressed. Since the last review, an additional mechanism for soliciting input on draft policies was their discussion at the Quality Assurance/Quality Improvement Committee meetings. Members of the Monitoring Team attended a meeting during the week of the onsite review at which several draft policies were discussed. The Committee provided practical input, and raised questions for the policies' authors to consider. This, in addition to the Policy and Review Committee, provided valuable forums for ensuring the comprehensiveness and effectiveness of the final policies.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	CCSSLC was conducting reviews of at least five records each month. The system for doing this, and particularly the processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends, were in the beginning stages of development. The reviews of records were being conducted on a couple of levels, and different tools were being used to conduct the reviews. The following describes what the process was at the time of the Monitoring Team's January 2011 visit: ▪ The two Unified Record Clerks each were conducting monthly reviews of five Individual Notebooks and five Active Records. This resulted in 10 individuals' records being reviewed monthly. The review tool they used was designed to ensure that proper content was present in the correct order. It did not fully address the quality issues identified in Appendix D of the Settlement Agreement. A review of the completed forms between October and November 2010 showed that these were being completed, and issues identified. A shared folder had been developed on the Facility's server to allow the monitoring results to be shared with PSTs with the expectation that needed corrections be made. The Unified Records Clerks indicated they used email to follow-up on needed changes.	Noncompliance

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		▪ The Quality Enhancement Office completed two reviews of records that the Unified Records Clerks also had reviewed. This review was conducted using a different tool that addressed more of the requirements of Section V. ▪ According to the Facility's POI, the QE's Program Compliance staff also conducted 16 reviews monthly that assessed the quality of the information included in the records. Any concerns identified were shared with PSTs. Beginning in February 2011, the Facility was going to begin using the Section V tool that had been developed by the Monitoring Teams, but then revised by the State Office. Efforts had begun to ensure that those conducting the audits had been properly trained, and that there was adequate inter-rater reliability. For example, during the last review, the Monitoring Team identified that there was a discrepancy with regard to how the Facility was evaluating the Reiss Screen component of the record. The Facility had developed and was implementing an action plan to address this issue. As mentioned with regard to Section V.1, the Facility was developing a tracking/monitoring system to review the Integrated Progress Notes, and to interview staff with regard to their use of individuals' records. This will assist the Facility in evaluating its compliance particularly with Section V.4 of the Settlement Agreement. Trending of information gathered from such reviews had not yet occurred, but the QE Director indicated that there were plans to do so. It was anticipated that by the July review, aggregate data would be available for review. This will provide important information, and should result, as appropriate, in action plans to address areas of concern. Although the Facility was making progress in this area, continued efforts were needed to ensure that all of the components of the requirements set forth in Appendix D of the Settlement Agreement were addressed through the monitoring. In addition, tracking of corrective actions and review of data to identify and address trends were also in the development phases.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	During the review, the following issues were noted with regard to the availability and quality of the records, and the impact on the ability of staff to utilize records in making medical treatment and training decisions: ▪ With regard to medical records, in reviewing records onsite, it continued to be noted that significantly fewer documents had to be obtained from the units compared to the baseline review. ▪ Recording of data is a key part of recordkeeping, and the integrity of such data	Noncompliance

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		collection is key to the clinical decision-making process. In reviewing the collection of data for Positive Behavioral Support Plans and skill acquisition goals, it was determined that staff were not consistently and timely documenting data. Likewise, as noted with regard to Section M.1, nursing staff were not consistently documenting information in integrated progress notes, including seizures and results of hospitalizations. ▪ As noted with regard to Section M.1, from discussions with some of the nursing staff and review of the Nursing Department meeting minutes, there had been some problematic issues concerning having timely access to bowel records so that nurses could review these to determine if individuals needed additional medications. At the time of the review, there had been no resolution of the issue. The Facility should ensure that all information relating to the medical/psychiatric needs of the individuals are easily and timely assessable to clinical staff. ▪ As also noted with regard to Section M.1, the Facility should continue to ensure that other documents such as lab work, diagnostics, and consults are filed in a timely manner in the individuals' records. The Facility had developed a draft policy entitled Filing, dated 11/4/10, indicating that: "the File Clerk or designee will file any received document that is designated as a priority document within one working day of its completion after checking to ensure that the responsible team member has reviewed the document prior to filing as needed." Although a very positive step in ensuring that documents are filed timely in the record, a number of issues such as how a document is designated as priority should be further outlined. In keeping with this issue, the Facility might want to consider developing and implementing a tracking system to ensure that all documents as noted above are timely returned to the Facility and timely filed in the records. ▪ As noted above with regard to Section V.1 of the SA, efforts were being made to ensure that all disciplines were using the Integrated Progress Notes section in individuals' records.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. CCSSLC should continue to convert the Master Records to the new Table of Contents.
2. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures.
3. Efforts should continue to ensure that the staff responsible for conducting record audits are provided with necessary training, and inter-rater reliability should be established.
4. The monitoring of records should include all of the elements of Appendix D, such as legibility, and completeness of records.
5. Monitoring of records should result in action steps/plans to address individual as well as systemic issues as they are identified. As appropriate and necessary, such action plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. As

the plans are implemented, they should be monitored to ensure the desired outcomes are being achieved. If not, the plans should be modified.

6. Documents should be filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
7. As is specified in other sections of this report, improvements should be made with regard to the quality of the data and other information that is entered into individuals' records.

List of Acronyms Used in This Report

Acronym/ Symbol	Meaning
≥	Greater than or equal to
≤	Less than or equal to
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Automated External Defibrillator
ALS	Adult Life Skills
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
BACB	Behavior Analyst Certification Board
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BSC	Behavior Support Committee
BID	Twice a Day
BiPAP	Bilevel Positive Airway Pressure
BM	Bowel Movement
BMI	Body Mass Index
BSC	Behavior Support Committee
BSP	Behavior Support Plan
c	With
cc	Cubic Centimeters
CBC	Complete Blood Count
CCSSLC	Corpus Christi State Supported Living Center
CD	Communication Dictionary
C-Diff	Clostridium difficile
CDC	Centers for Disease Control
CE	Continuing Education
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Aide
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation

CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTD	Competency Training Department
CV	Curricula Vitae
DADS	Texas Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
d/c	Discontinued
DCP	Direct Care Professional
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DRA	Differential Reinforcement of Alternative Behavior
DRO	Differential Reinforcement of Other Behavior
DRR	Drug Regimen Reviews
DRM	Dining Room Monitor
DRT	Dining Room Transporter
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
ECU	Environmental Control Unit
EDO	Evening Duty Officer
EDWR	Established Desired Weight Range
EEG	Electroencephalogram
EGD	Esophagogastroduodenoscopies
EKG	Electrocardiogram
EMS	Emergency Medical Services
ENT	Ear, Nose, and Throat
ER	Emergency Room
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FNP	Family Nurse Practitioner
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy feeding tube
GJ-tube	Gastrostomy/Jejunostomy or transgastric feeding tube
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HDS	Home Dining Supervisor
HIV	Human Immunodeficiency Virus

HMP	Health Management Plan
h/o	History of
HRC	Human Rights Committee
hs	At night
HST	Health Status Team
HT	Habilitation Therapies
IBWR	Ideal Body Weight Range
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facilities for persons with Mental Retardation
ID/DD	Intellectual Disabilities/Developmental Disabilities
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Incident Management
IMC	Incident Management Coordinator
IMT	Incident Management Team
IOA	Inter-observer Agreement
IPN	Integrated Progress Notes
ITTP	Individual Treatment Training Plan
IV	Intravenous
J-tube	Jejunostomy feeding tube
LAR	Legally Authorized Representative
LOS	Level of Supervision
LOSOC	Level of Supervision Oversight Committee
LVN	Licensed Vocational Nurse
MAC	Monitored Anesthesia Care
MAR	Medication Administration Record
MAS	Motivation Assessment Scale
MBS(S)	Modified Barium Swallow Study
MD	Medical Doctor
mg	Milligrams
MH	Mental Health
MHMR	Mental Health Mental Retardation
ml	milliliters
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
n	Sample of the Population Audited

N	Total Population Being Reviewed
NM	Nutritional Management
NMT	Nutritional Management Team
NOO	Nursing Operational Officer
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OCD	Obsessive Compulsive Disorder
OHR	Oral Health Rating
ORIF	Open reduction internal fixation
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Adaptive Living Skills
PBSP	Positive Behavior Support Plan
PCM	Program Compliance Monitor
PCP	Primary Care Practitioner
PEG	Percutaneous Endoscopic Gastrostomy
PFA	Personal Focus Assessment
PIC	Performance Improvement Council
PIT	Performance Improvement Team
PMAB	Prevention and Management of Aggressive Behavior
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PNS	Physical and Nutritional Supports
PO	By mouth
POI	Plan of Implementation
PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PSR	Psychiatric Services Review
PST	Personal Support Team
PT	Physical Therapist
P&T	Pharmacy and Therapeutics
PTA	Physical Therapist Assistant
PUSH	Pressure Ulcer Healing Graph
RATM	Review Authority Team Meeting
REACT	Respiration, Energy, Alertness, Circulation, and Temperature
RD	Registered Dietician
RN	Registered Nurse

ROM	Range of Motion
RT	Respiratory Therapist
RTT	Residential Treatment Technician
q	Each
QA	Quality Assurance
QE	Quality Enhancement
QI	Quality Improvement
QID	Four times a day
QMRP	Qualified Mental Retardation Professional
RN	Registered Nurse
SA	Settlement Agreement in U.S. v. Texas
SA	Speech Assistant
SAC	Settlement Agreement Coordinator
SAO	Skill Acquisition Objective
SAP	Skill Acquisition Plan
SAMS	Self-Administration of Medication
SFBA	Structured Functional Behavior Assessment
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathologist
SNF	Skilled Nursing Facility
SOAP	Subjective, Objective, Assessment, and Plan
SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSO	Staff Service Objective
Stat	Immediately
STD	Sexually-transmitted disease
UGI	Upper Gastrointestinal
UNT	University of North Texas
UTI	Urinary Tract Infection
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UA	Urinalysis
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulator
WBC	White Blood Count
WC	Wheel Chair